

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 07/17/23</p> <p>Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100</p> <p>At this Emergency Preparedness survey, Morning Breeze Retirement Community and Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 64 certified beds. At the time of the survey, the census was 52.</p> <p>Quality Review completed on 07/19/23</p>			E 0000	Please disregard the waiver initially discussed. We have concrete scheduled to correct the K271 tag on or before 8/10/23.		
K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 07/17/23</p> <p>Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100</p> <p>At this Life Safety Code survey, Morning Breeze</p>			K 0000	Please disregard the waiver initially discussed. We have concrete scheduled to correct the K271 tag on or before 8/10/23.		

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

TITLE

(X6) DATE

Holly Witkemper

HFA

07/28/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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.

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0211 SS=F Bldg. 01	<p>Retirement Community and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 52 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 07/19/23</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure the corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for</p>			K 0211	<p>K211- Means of Egress</p> <p>Correction action to be accomplished for residents found to have been affected by the</p>		08/10/2023

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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			
	<p>wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches.</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., in resident halls Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be moved out of the halls during an emergency. The PPE carts without wheels were observed by rooms 41, 44, 81 & 69. Based on an interview at the time of observations, the Maintenance Director stated the PPE carts were not equipped with wheels and would need to be replaced with PPE carts with wheels.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p>		<p>deficient practice:</p> <p>- Identified rooms 41,44,81 & 69 units that had sliders in place of wheels. Wheels are in place at this time.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>- All residents had the potential to be effected. New carts have been obtain.</p> <p>What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur:</p> <p>- Walking rounds will be performed Monday-Friday, to verify all wheels are in working condition. performed by the Maintenance Director or designee.</p> <p>- Ongoing education with staff, on the importance of wheels being in working condition outside of rooms.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>- A performance improvement tool has been developed that will monitor PPE carts wheels are in place. PI tool will be completed by the Maintenance Director or designee daily Monday thru Friday for one</p>				

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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	
K 0271 SS=E Bldg. 01	<p>NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 4 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., the exit discharge near the smoking area was uneven where the sidewalk and blacktop meet. Where the concrete and blacktop meet there was 2 to 3 inches of uneven grade. Based on interview at the time of observation, the Maintenance Director stated that when the driveway was redone, they cut the sidewalk and that created the uneven ledge. There was evidence that previously a concrete slope had been in this location.</p>		K 0271	<p>month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes.</p> <p>K271- Discharge from exits</p> <p>Correction action to be accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - 2 inch of uneven grade slope to be corrected. Concrete has been scheduled to be poured to correct uneven slope. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents had the potential to be effected. Concrete will be completed by 8/10/2023 <p>What measures will be put in place and what systematic</p>		08/10/2023	

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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	
K 0325 SS=E Bldg. 01	<p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p> <p>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</p>			<p>changes will be made to ensure that the deficient practice not recur:</p> <ul style="list-style-type: none"> - Walking rounds will be performed Monday-Friday, to verify all Exit Discharge areas meet regulation for discharge. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> - A performance improvement tool has been developed that will monitor discharge slopes at exits. PI tool will be completed by the Maintenance Director or designee once a month for 6 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes. 			

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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			
	<p>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</p> <p>* Dispensers are not installed within 1 inch of an ignition source</p> <p>* Dispensers over carpeted floors are in sprinklered smoke compartments</p> <p>* ABHR does not exceed 95 percent alcohol</p> <p>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</p> <p>* ABHR is protected against inappropriate access</p> <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1-inch vertical distance from the ignition source</p> <p>This deficient practice could affect 20 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall above an electrical outlet in the corridor by room #71. Based on interview at the time of observation, the Maintenance Director confirmed the alcohol-based hand sanitizer</p>	K 0325	<p>K325 ABHR</p> <p>Correction action to be accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - Alcohol based hand sanitizer dispenser was moved from the outlet area. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents had the potential to be effected. Immediate assessment of all ABHS dispensers completed with no other concerns. Immediate replacement completed of the one identified. <p>What measures will be put in place and what systematic changes will be made to ensure</p>	08/10/2023			

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0341 SS=F Bldg. 01	<p>dispenser was installed on the wall above an electrical outlet in the corridor by room 71.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and</p>				<p>that the deficient practice not recur:</p> <p>- Walking rounds will be performed Monday-Friday, to verify all ABHS stations are not near outlets performed by the Maintenance Director or designee.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>- A performance improvement tool has been developed that will monitor the location of ABHS stations and that there is no concerns with outlets being to close. PI tool will be completed by the Maintenance Director or designee daily Monday thru Friday for one month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes.</p>		

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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		
	<p>supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.</p> <p>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., the fire alarm control panel (FACP) door was not locked. The lock set tumbler was missing from the door protecting the FACP. The FACP was located in a high traffic area in the main corridor near the main entry.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p>	K 0341	<p>K341- Fire Alarm System-Installation</p> <p>Correction action to be accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - Immediate action was taken to secure the Fire control panel door. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents had the potential to be effected. Panel is secured with lock. <p>What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur:</p> <ul style="list-style-type: none"> - Walking rounds will be performed Monday-Friday, to verify placement of lock is secure performed by the Maintenance Director or designee. - Ongoing education with staff, on the importance of the door being locked on panel. <p>How the corrective actions will be</p>		08/10/2023		

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0353 SS=C Bldg. 01	<p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler</p>			K 0353	<p>monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor the door is locked on the panel. PI tool will be completed by the Maintenance Director or designee daily Monday thru Friday for one month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes.</p> <p>353- Sprinkler System</p> <p>Correction action to be</p>		08/10/2023

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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
	<p>cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., there was one spare sprinkler cabinet in the riser room that included spare sprinklers, 6 of which were not in their own protected slot. They were stored loose in the cabinet and on the cabinet. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabin had spare sprinklers not in protected slots.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p>				<p>accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - New Head box being installed with all relevant Replacement heads inside. As well as an Inventory list with head count located below the head box. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents had the potential to be effected. New head box installed and inventory list in place. <p>What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur:</p> <ul style="list-style-type: none"> - Walking rounds will be performed Monday-Friday, to verify Sprinkler Head Box is stocked and literature is present performed by the Maintenance Director or designee. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> - A performance improvement tool has been developed that will monitor compliance of sprinkler head cabinet and information 		

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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
K 0712 SS=C Bldg. 01	<p>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 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director and Administrator on 07/17/23 between 10:45 a.m. and 12:40 p.m., 8 of 12 quarterly fire drills were conducted near the end of the month, between the 26th and 30th day of the month. These conditions do not allow fire drills to</p>			K 0712	<p>documentation at site. PI tool will be completed by the Maintenance Director or designee daily Monday thru Friday for one month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes.</p> <p>K712- Fire Drills</p> <p>Correction action to be accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - Fire Drills have been scheduled for the next 6 months to alternate shift and time of month. <p>How other residents having the potential to be affected by the same deficient practice will be</p>		08/10/2023

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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	
K 0920 SS=E Bldg. 01	<p>be conducted on unexpected and unpredictable days.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been</p>			<p>identified and what corrective action will be taken:</p> <p>- All residents had the potential to be effected. Scheduled fire drills to ensure alternating times and dates for 6 months.</p> <p>What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur:</p> <p>6 Month schedule in place that identifies off set of dates and shifts for drills.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>- A performance improvement tool has been developed that will fire drill dates and shift. Maintenance or designee will complete audit tool each Monday for 6 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes.</p>			

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

PRINTED: 08/02/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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
	<p>assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 4 staff.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., in the (1) Director of Admissions Office (2) Executive Directors Office a power strip was being used to power a dorm style refrigerator (high power draw equipment).</p> <p>This finding was acknowledged by the</p>			K 0920	<p>K920- Electrical Equipment- Power Cords and extension cords</p> <p>Correction action to be accomplished for residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> - Extension Cords removed from Building. - Immediate action was taken to ensure power strips do not have medical and personal mix equipment. Power strips removed from areas being used for dorm style fridge. This was corrected 7/18/23 <p>How other residents having the potential to be affected by the same deficient practice will be</p>		08/10/2023

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 10 residents.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Maintenance Director on 07/17/23 between 12:40 p.m. and 2:30 p.m., extensions cords were in use (1) in RR # 51 powering electronic equipment and (2) outside the dining area exit powering a water fountain.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.</p> <p>3.1-19(b)</p>				<p>identified and what corrective action will be taken:</p> <ul style="list-style-type: none"> - All residents had the potential to be effected. All residents with power strips were identified and no other issues were found. All staff offices were observed and no additional issues identified. - All rooms had environmental sweep completed with no extension cords identified. <p>What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur:</p> <ul style="list-style-type: none"> - Walking rounds will be performed Monday-Friday, to verify NO extension cords in use and power strips are used appropriately performed by the Maintenance Director or designee. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> - A performance improvement tool has been developed that will monitor for extension cords and appropriate power strip use. PI tool will be completed by the Maintenance Director or designee daily Monday thru Friday for one month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI 		

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC				STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR GREENSBURG, IN 47240			
(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
					review of findings, results, outcomes.		