PRINTED: 03/01/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155719	B. WING		02/07/2024	
GEORGI (X4) ID PREFIX	SUMMARY (EACH DEFICIEN	HEALTH CARE CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	3623 E BROO ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
E 0000 Bldg	conducted by the Irraccordance with 42 Survey Date: 02/07 Facility Number: 00 Provider Number: 1002 At this Emergency Ade Memorial Hea in compliance with Requirements for National Provides 483.73 The facility has 70 the survey, the cens	7/24 00559 155719 267170 Preparedness survey, George lth Care Center was found not Emergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of	E 0000	Brenda Buroker, Director Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, IN 46204-3006 Re: POC for the annual Surve Event ID: Y9JC21, George Ad Memorial Health Care Center, Brook, IN., on February 7, 202 Dear Brenda: The following plan of correction being submitted as our allegar of substantial compliance. We further submit that the facility substantial compliance as of March 1, 2024. At this time, we are requesting the Indiana State Department of Health conduct desktop review of the survey of th	ey de , 24. on is tion e is in we ate t a to to to ave	

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

(X6) DATE

TITLE

Scott James **HFA** 02/23/2024

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

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AND PLAN OF C		IDENTIFICATION NUMBER 155719	A. BUILDING B. WING		COMPLETED 02/07/2024	
	VIDER OR SUPPLIER DE MEMORIAL H	HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922			
(X4) ID PREFIX TAG	(EACH DEFICIENC	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	
				any way possible.		
				Thank you,		
				Scott James, HFA GAMHCC		
				The preparation and execution this Plan of Correction does no constitute admission or agree by the provider of the truth of facts alleged or the conclusion forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alledeficiencies do not individually collectively jeopardize the heat and safety of its residents, not they of such character as to lith this provider's capacity to rendadequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided the procedural preceding purposition to comply with state and feder regulations, and correlate with	ot ment the n set of he eged y or alth r are mit der der do soses ral	

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Event ID:

Y9JC21

Facility ID: 000559

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	OF CORRECTION	IDENTIFICATION NUMBER 155719	A. BUILDING B. WING		COMPLETED 02/07/2024
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				most recent contemplated or accomplished corrective action. These dates do not necessar correspond chronologically to date the provider is under the opinion it was in with requirem of participation or that the corrective action was necessar.	the nents
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 §460.84(d)(2), §48 §483.475(d)(2), §4	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)			
	OPO, "Organization CMHCs at §485.9. §491.12, and ESR (2) Testing. The [factorises to test the company of the co	6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at ED Facilities at §494.62]: acility] must conduct ne emergency plan lity] must do all of the			
	following: (i) Participate in a community-based (A) When a community accessible, confunctional exercises (B) If the [facily natural or man-material contents or material contents or man-material contents or material contents or mate	full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	ľ	UILDING	NSTRUCTION	COM	e survey pleted 17/2024
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 (, IN 47922		_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE
	community-based functional exercise actual event. (ii) Conduct an ad every 2 years, oppor functional exercise (i) of this section include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an erecise, and emetate (iii) Analyze the [famaintain documerexercises, and emetate [facility's] emetate (2) Testing for hothe patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based (A) When a community based functional exercises man-made emerging of the emergency	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and atation of all drills, tabletop mergency events, and revise rgency plan, as needed. 418.113(d):] spices that provide care in a. The hospice must to test the emergency ally. The hospice must do					

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Event ID:

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155719	 UILDING	INSTRUCTION	COMP1 02/07	
	F PROVIDER OR SUPPLIEF	HEALTH CARE CENTER	 3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	facility-based functionset of the emergency events (ii) Conduct an adverse of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an error (3) Testing for hose care directly. The exercises to test the per year. The hose (i) Participate in a that is community (A) When a community (B) If the hospice man-made emergency exempt from engate full-scale community (B) If the hospice man-made emergency events (ii) Conduct an activate may include, following:	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: scale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise based; or aunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based e following the onset of the				

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PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719		A. BUILDING CO			(X3) DATE COMPL 02/07	ETED
	PROVIDER OR SUPPLIE	R HEALTH CARE CENTER		3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 (, IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PLISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	community-based functional exercises (B) A mock disast (C) A tabletop expectable facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the maintain docume exercises, and erthe hospice's emergency lander the hospice's emergency plan. (2) Testing. The [conduct exercises plan twice per year (CAH] must do the (i) Participate in that is community (A) When a community (A) When a community (B) If the [PRTF, an actual natural that requires active plan, the [facility] its next required for individual, facilifollowing the onse (ii) Conduct exercise or and the limited to the following the onse (iii) Conduct exercise or and the community-based full community	ster drill; or sercise or workshop led by a udes a group discussion clinically-relevant ario, and a set of problem sted messages, or prepared sed to challenge an anospice's response to and intation of all drills, tabletop inergency events and revise ergency plan, as needed. 441.184(d), Hospitals at as at §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency ar. The [PRTF, Hospital, as following: an annual full-scale exercise are annual individual, citional exercise; or Hospital, CAH] experiences or man-made emergency aration of the emergency aration of the emergency is exempt from engaging in ull-scale community based ity-based functional exercise at of the emergency event. an [additional] annual mat may include, but is not awing: -scale exercise that is					DATE

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	ľ	UILDING	NSTRUCTION	COM	E SURVEY PLETED 7/2024	
	F PROVIDER OR SUPPLIE	R HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	(C) A tableto is led by a facilitar discussion, using clinically-relevant set of problem star messages, or preto challenge an e (iii) Analyze that and maintain doctabletop exercises and revise the [faneeded. *[For PACE at §4 (2) Testing. The Founduct exercises plan at least annuorganization musically (A) When a community (A) When a community (B) If the PACE error man-made emactivation of the error is exempt from error full-scale community acility-based functions of the emer (ii) Conduct at 2 years opposite functional exercise of this section is of but is not limited to (A) A second fullity-based functional exercise of this section is of but is not limited to (A) A second fullity-based functional exercise of this section is of but is not limited to (A) A second fullity-based functional exercise of this section is of but is not limited to (A) A second fullity-based functional exercise of this section is of but is not limited to (A) A second fullity-based functional exercise of the section is of but is not limited to (A) A second fullity-based functional exercise of the section is of but is not limited to (A) A second fullity-based functional exercise of the section is of but is not limited to (A) A second fullity-based functional exercise of the section is of the section	emergency scenario, and a atements, directed apared questions designed mergency plan. The [facility's] response to umentation of all drills, as, and emergency events cility's] emergency plan, as 60.84(d):] PACE organization must as to test the emergency ually. The PACE at do the following: an annual full-scale exercise an annual individual, ctional exercise; or experiences an actual natural ergency that requires emergency plan, the PACE angaging in its next required anity based or individual, ctional exercise following the ergency event. In an additional exercise every the year the full-scale or the under paragraph (d)(2)(i) conducted that may include, to the following: -scale exercise that is dor individual, a facility exercise; or						

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Event ID:

Y9JC21

Facility ID: 000559

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	r í	UILDING	NSTRUCTION	COM	TE SURVEY MPLETED 07/2024	
	OF PROVIDER OR SUPPLIE	R HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an e (iii) Analyze the I maintain docume exercises, and er the PACE's emer *[For LTC Facilitic (2) The [LTC facilito test the emergy year, including ur the emergency properties of the properti	remergency scenario, and a retements, directed repared questions designed mergency plan. PACE's response to and ntation of all drills, tabletop mergency events and revise gency plan, as needed. res at §483.73(d):] response to and revise gency plan, as needed. res at §483.73(d):] response to and revise gency plan, as needed. response to and revise gency plan, as needed. response to and revise gency plan, as needed. response to and revise gency plan at least twice per mannounced staff drills using recedures. The [LTC facility, the following: response to an annual full-scale exercise repared to an annual full-scale exercise is not functional exercise. response to an annual individual, retional exercise. response to an annual individual, the rempt from engaging its next response to the emergency plan, the rempt from engaging its next response to the emergency event. The response to the exercise that is done an individual, facility exercise; or seter drill; or response to the emergency event is not limited to the response to the exercise or workshop that is a includes a group						

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	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155719	UILDING		COMP1 02/07	
	PROVIDER OR SUPPLIER E ADE MEMORIAL	HEALTH CARE CENTER	3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	set of problem star messages, or prejet to challenge an er (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, a *[For ICF/IIDs at § (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community. (A) When a commaccessible, conducted facility-based function of the exercise to the exercise to test the twice per year. The following: (i) Participate in an activation of the exercise for man-maccessible, conducted facility-based functions of the emergical formula or man-maccessible community facility-based functions of the emergical formula on the exercise following: (A) A second full-second full	pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. [483.475(d)]: CF/IID must conduct he emergency plan at least e ICF/IID must do the manual full-scale exercise rebased; or munity-based exercise is not ct an annual individual, etional exercise; or. Experiences an actual ade emergency plan, the ICF/IID gaging in its next requires mergency plan, the ICF/IID gaging in its next required mity-based or individual, etional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a				

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER 155719	 UILDING	INSTRUCTION	COMPI 02/07	LETED
	PROVIDER OR SUPPLIER		3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16		
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER	BROOK	K, IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	maintain documer exercises, and em the ICF/IID's emer	CF/IID's response to and ntation of all drills, tabletop nergency events, and revise rgency plan, as needed.				
	exercises to test the least annually. The following:	e HHA must conduct he emergency plan at e HHA must do the				
	community-based (A) When a c	full-scale exercise that is ; or ommunity-based exercise conduct an annual				
	every 2 years; or. (B) If the HH	A experiences an actual				
	activation of the element from enga	ade emergency that requires mergency plan, the HHA is aging in its next required hity-based or individual,				
	facility based functionset of the emerg	tional exercise following the				
	years, opposite th	e year the full-scale or e under paragraph (d)(2)(i)				
		limited to the following: full-scale exercise that is or an individual,				
	(C) A tabletop	isaster drill; or o exercise or workshop that				
	discussion, using	emergency scenario, and a				
	•	pared questions designed				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	ì í	UILDING	NSTRUCTION	COM	TE SURVEY MPLETED 07/2024	
	PROVIDER OR SUPPLIEI	R HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	(iii) Analyze the H maintain docume exercises, and en the HHA's emerged *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor workshop at least exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing e of the emergency (ii) Analyze the Omaintain docume exercises, and en the [RNHCI's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCI must do to the conduct a papat least annually. Group discussion narrated, clinically scenario, and a service services.	R LSC IDENTIFYING INFORMATION IHA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically icy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset event. PO's response to and intation of all tabletop inergency events, and revise OPO's] emergency plan, as 3.748]: e RNHCI must conduct the emergency plan. The		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE	
	designed to challe	enge an emergency plan. NHCl's response to and						

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Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	,	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155719	B. WI	NG		02/07/	/2024
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922				
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintain documer exercises, and enthe RNHCl's emel Based on record revialled to conduct explan at least twice punannounced staff oprocedures. The LT following: (i) Participate in an is community-based a. When a communaccessible, conduct facility-based funct b. If the LTC facility or man-made emergof the emergency pfrom engaging its not more to the actual community-based of the conset of the actual community community-based of the conset of the actual community community-based of the conset of the actual community community community-based of t	ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility nercises to test the emergency per year, including drills using the emergency referency exercise to the temperature referency	E 00	TAG	CROSS-REFERENCED TO THE APPROPRIA	ling. as s. se ated e urvey for the 2). d to	
	1	4	1				

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED 02/07/2024	
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	362	EET ADDRESS, CITY, STATE, ZIP COD 23 EAST STATE RD 16 OOK, IN 47922	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE
	Preparedness Plan of to 12:50 p.m. with the documentation of an was documented as A second full-scale community-based of functional exercise, tabletop exercise or facilitator that incluse a narrated, clinically and a set of problem messages, or preparachallenge an emergence review. Based on in review, the Administ exercise of choice he facility as of the times.	being completed on 06/20/23. exercise that is r an individual, facility-based or a mock disaster drill, a workshop that is led by a des a group discussion, using r relevant emergency scenario, a statements, directed ed questions designed to ency plan was not available to terview at the time of record strator agreed that a second ad not been completed by the ne of this survey.			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/07/ Facility Number: 00 Provider Number: 1 AIM Number: 1002	00559 55719 67170	K 0000	February 23, 2024 Brenda Buroker, Director Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-t Indianapolis, IN 46204-3006	
	At this Life Safety (Code survey, George Ade		Re: POC for the annual Sur	vey

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	OF CORRECTION	IDENTIFICATION NUMBER 155719	A. BUILDING B. WING	01	COMPLETED 02/07/2024
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE
	compliance with Re Medicare/Medicaid Life Safety from Fin	are Center was found not in equirements for Participation in 42 CFR Subpart 483.70(a), are and the 2012 edition of the ection Association (NFPA) 101,		Event ID: Y9JC21, George Ad Memorial Health Care Center Brook, IN., on February 7, 202 Dear Brenda:	,
	Life Safety Code (L Health Care Occupa This one-story facil: Type II (222) constr sprinklered. The fac with hard wired smo spaces open to the c rooms. The facility census of 56 at the t	ity was determined to be of ruction and was fully fility has a fire alarm system oke detection in corridors, orridors, and in all resident has a capacity of 70 and had a ime of this survey. dents have customary access reas providing facility services		The following plan of correction being submitted as our allegat of substantial compliance. Where further submit that the facility substantial compliance as of March 1, 2024. At this time, we are requesting the Indiana Standard Department of Health conduct desktop review of the survey clear the survey findings and stop any and all proposed or implemented remedies that he been presented to date. If you have any questions or refurther information, call 219-275-2531 or email admin@georgeade.org, and I	tion e is in we ate t a to to ave
				would be available to assist yeany way possible. Thank you, Scott James, HFA GAMHCC The preparation and execution this Plan of Correction does not constitute admission or agree by the provider of the truth of	n of ot ment

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/07/2024
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE RD 16 K, IN 47922	
GEORGE (X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) facts alleged or the conclusion forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the all deficiencies do not individuall collectively jeopardize the heat and safety of its residents, not they of such character as to lithis provider's capacity to renadequate resident care. Furthermore, the operation at licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provides	n set of the leged y or alth or are imit der
K 0345 SS=F Bldg. 01	the puto con regular most according to contract the puto contract		the procedural preceding pur to comply with state and fede regulations, and correlate wit most recent contemplated or accomplished corrective action. These dates do not necessar correspond chronologically to date the provider is under the opinion it was in with requirer of participation or that the corrective action was necessar	poses ral h the on. ily the ments	

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i '		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		155719	B. W	WING 02/07/2		/2024		
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEOVIDERIC N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
IAG	A fire alarm syster 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 Based on record reversity failed to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual insperaccordance with the more often if requiringuirisdiction. Table 1 must be visually insa. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient pract in the facility. Findings include: Based on record reversity Maintenance Supermo documentation of visual semi-annual The annual fire alar 01/12/24 but there we documented six mo Based on interview the Maintenance Supermo Based on Inte	m is tested and maintained in an approved program are requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by actions shall be performed in a schedules in Table 14.3.1, or and 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 0	345	Desk top review requested No residents were found to be negatively affected by this find. Testing is being performed as February 23, 2024 the schedutesting will be one on an annusemiannual schedule to maint compliance. The pump testing company wiprovide a regular schedule for testing as well as support and service for any area found in rof attention. (Attachment) This will be maintained by the maintenance supervisor or designee as well as the administrator to maintain compliance. This is ongoing. This is done as of 3/1/2024	ding. of ule of al/ ain	03/01/2024	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 02/07/2024
	PROVIDER OR SUPPLIER E ADE MEMORIAL	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	
(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 0353	was not available as This finding was re	of the time of this survey. viewed with the Administrator e Supervisor at the exit			
SS=F Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and tes secure location are	- 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, etting are maintained in a lid readily available. system last checked			
	b) Who provided c) Water system				
	Provide in REMAR coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to ma accordance with NF Inspection, Testing, Water-Based Fire P Section 8.3.3.1 state pump assembly sha personnel under min of the fire pump by water discharged th	RKS information on non-required or partial r system.	K 0353	Desk top review requested No residents were found to have been negatively affected by the findings. The request testing of the fire panel, sprinkler head cabinet, a head replacement for the walk-cooler have been scheduled. Talong with the fourth quarter sprinkler system inspection (se attached) has been completed.	and in his

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PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION visitors, and residents in the facility. visitors, and residents in the facility. During record review with the Maintenance Supervisor on 02/07/24 at 12:05 p.m., annual testing of the facility's fire pump within the last twelve months was not available for review, the Maintenance Supervisor stated the facility has an electric fire pump, and agreed that an annual fire pump test inspection was not available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler 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		MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	l í	JILDING	onstruction 01	(X3) DATE COMPL 02/07 /	ETED
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION visitors, and residents in the facility. visitors, and residents in the facility. During record review with the Maintenance Supervisor on 02/07/24 at 12:05 p.m., annual testing of the facility's fire pump within the last twelve months was not available for review, the Maintenance Supervisor stated the facility has an electric fire pump, and agreed that an annual fire pump test inspection was not available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler 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					3623 E	AST STATE RD 16		
visitors, and residents in the facility. Findings include: During record review with the Maintenance Supervisor on 02/07/24 at 12:05 p.m., annual testing of the facility's fire pump within the last twelve months was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has an electric fire pump, and agreed that an annual fire pump test inspection was not available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler 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	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE
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. Findings include:	TAG	visitors, and resident Findings include: During record revice Supervisor on 02/0 testing of the facility twelve months was on interview at the Maintenance Super electric fire pump, pump test inspection at the time of the sufficient of the suffic	ew with the Maintenance 7/24 at 12:05 p.m., annual ty's fire pump within the last not available for review. Based time of record review, the rvisor stated the facility has an and agreed that an annual fire on was not available for review arvey. Eviewed with the Administrator upervisor at the exit ation and interview, the facility of 1 sprinkler systems was are sprinklers, a spare sprinkler kler wrench on the premises. If for the Inspection, Testing, of Water-Based Fire Protection tion, Section 5.4.1.4 states a inklers (never fewer than six) I on the premises so that any the been operated or damaged in the property. The kept in a cabinet located where which they are subjected will at the degrees Fahrenheit. A special hall be provided and kept in the on the removal and installation deficient practice could affect		TAG	The testing and observation of equipment will be scheduled for continuity of service and upker. The maintenance supervisor of designee and administrator will monitor the testing and results. This is ongoing.	or a ep. or II	DATE

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	JILDING	nstruction 01	(X3) DATE COMPI 02/07	
	PROVIDER OR SUPPLIEI	HEALTH CARE CENTER	3623 EA	AST STATE RD 16 (, IN 47922	•	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE
	with the Maintenar Administrator on 0 sprinkler cabinet in sprinklers lying loc sprinklers. Based o observation, the Mathat all the spare sprotected slot to protected slot to protect slots and maintenance Sconference. 3. Based on record facility failed to protected slots are evidence the had been inspected LSC 4.6.12.1 requires yetem required for maintained in according requirements. Sprimaintained in according spections, tests, a components and shouthority having jurequires that recording performed (e.g., instead the organization that results, and the date waterflow alarm dequarterly to verify to water motor gordinary damage. NFPA 25 waterflow alarm deto, water motor gordinary specifical springer shouthout such specific specifical specif	2/07/24 at 2:00 p.m., the spare the riser room had five spare se on top of other spare in interview at the time of the aintenance Supervisor agreed rinklers were not in their own				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	 JILDING	nstruction 01	(X3) DATE COMPL 02/07/	ETED
	PROVIDER OR SUPPLIER E ADE MEMORIAL	HEALTH CARE CENTER	3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 C, IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	tested semiannually	ow alarm devices shall be This deficient practice could staff, and visitors in the				
	Based on review of inspection records of the Maintenance Su quarterly sprinkler available for the for November, and Decobservation with the during a tour of the inspection tag at the date of 10/27/23. Be record review, the Noremed there was to review for the for This finding was re-	the quarterly sprinkler system on 02/07/24 at 12:00 p.m. with apervisor present, there was no system inspection report arth quarter (October, cember) of 2023. Based on the Maintenance Supervisor facility, the sprinkler the riser indicated an inspection ased on interview at the time of Maintenance Supervisor in spection report available that quarter of 2023.				
	facility failed to east behind the Laundry were replaced or cle NFPA 25. NFPA 2 Testing, and Mainte Protection Systems, states sprinklers sha shall be free of corr and physical damag correct orientation (sidewall). Furthern	ation, and interview; the sure 1 of 1 sprinkler heads room dryers covered with lint eaned in accordance with 5, Standard for the Inspection, enance of Water-Based Fire, 2011 Edition, Section 5.2.1.1.1 all not show signs of leakage; osion, foreign materials, paint, se; and shall be installed in the (e.g., up-right, pendent, or nore, at 5.2.1.1.2 any sprinkler any of the following shall be				

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	OF CORRECTION	IDENTIFICATION NUMBER 155719	UILDING	01	COMPL 02/07/	ETED
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 EA	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 I, IN 47922		
(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)	TE	(X5) COMPLETION DATE
K 0712	(2) Corrosion (3) Physical Damag (4) Loss of fluid in relement (5) Loading (6) Painting unless paramufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not This deficient practic kitchen. Findings include: Based on observation Supervisor during a p.m. to 2:10 p.m. or sprinkler located in kitchen was covered Based on interview Maintenance Supervaforementioned autowith a foreign substitution.	the glass bulb heat responsive painted by the sprinkler sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the touch the sprinkler. Ice could affect staff in the on with the Maintenance tour of the facility from 12:55 in 02/07/24, the glass bulb of the the walkin cooler in the d with a foreign substance. at the time of observation, the visor agreed the omatic sprinkler was loaded ance.				
SS=F Bldg. 01	Fire Drills Fire Drills Fire drills include t alarm signal and s conditions. Fire dr and unexpected til	he transmission of a fire imulation of emergency fire ills are held at expected mes under varying t quarterly on each shift.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155719	B. WING		/2024	
NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER		3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922			
(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)	ATE	(X5) COMPLETION DATE
	The staff is familia aware that drills a routine. Where di 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record refailed to conduct quarters. LSC 19.7 conducted quarterly conditions. This defand residents. Findings include: Based on record refailed to conducted quarterly conditions. This defand residents. Findings include: Based on record refailed to conducted first quarter (Januar 2023/2024 first shifthet time of record refailed to conducted in Januar additional fire drill review at the time of This finding was refailed.	ar with procedures and is re part of established rills are conducted between AM, a coded ay be used instead of 19.7.1.7 view and interview, the facility parterly fire drills for 1 of 4 1.6 requires drills to be on each shift under varied ficient practice affects all staff view with the facility visor on 02/07/24 at 11:10 a.m., could be provided regarding a ry, February, and March) of at fire drill. Based on interview at eview, the Maintenance first shift fire drill was not ry 2024 and that there was no documentation available for	K 0712	Desk top review requested No residents were found to be negatively affected by this fine The fire drill schedule is in full effect. Drills are being conduct once per shift per quarter. (Se attached) The fire drills required informat are now being used on an one basis with three drills per cale quarter. The maintenance supervisor of designee and administrator w maintain and provide the necessary drill information pe regulations so as to maintain compliance. This is ongoing. This is done as of 3/1/2024	ding. I I I I I I I I I I I I I I I I I I I	03/01/2024

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