STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING -- B. WING	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/04/22 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Emergency Preparedness survey, The Waters of Scottsburg was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 99 certified beds. At the time of the survey, the census was 70. Quality Review completed on 01/06/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/04/22 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Life Safety Code survey, The Waters of Scottsburg was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 99 and had a census of 70 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 01/06/22			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to install proper exit signage at 1 of 11 doors that should be identified as an exit in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously	K 0293	**K293**– It is the intent of the facility to ensure to provide and maintain proper exit signage at doors that should be identified as an exit in the facility to meet set	01/17/2022

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	and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 21 residents and staff in the Memory Springs unit. Findings include: Based on observations on 01/04/22 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director from a sister facility, there was no illuminated EXIT sign over the Memory Springs unit Dining Room exit door. This door was marked as an exit door on the provided floor plan. Based on interview at the time of observation, the Maintenance Director agreed this exit was not provided with an illuminated EXIT sign above the door. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 1/14/2022 the Maintenance Supervisor/designee installed an illuminated exit sign over the Memory Springs Unit Dining Room exit door to meet set standards. The Administrator verified the work on 1/17/2022 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 1/14/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all exits must be identified with proper signage and a visual check must be conducted on all exit lights, signs, and all interior hallway lights in all corridors and common areas weekly to include checking for any burned-out bulbs and those inspections must be documented on the Emergency-Powered Lighting and Exit Signs Log to meet set standards. 2.Maintenance Supervisor/designee will conduct a visual check of all exit lights, signs, and interior hallway/common area lights weekly and document those inspection results on the	

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			Emergency-Powered Lighting and Exit Signs Log as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/17/2022.**	

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K 0353 SS=B Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the ceiling in 1 of 7 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect staff while in the Memory Springs Pantry. Findings include: Based on observations on 01/04/22 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director from a sister facility, there was a one inch hole with a TV cable in the ceiling of the Memory Springs Pantry that was not properly fire stopped, furthermore, there was a quarter inch hole around a metal conduit also in the ceiling of the Memorial Springs Pantry that was not properly fire stopped. Based on interview at the time of each observation, the Maintenance	K 0353	**K353** – It is the intent of the facility to ensure the ceiling in sprinklered smoke compartments are maintained to allow sprinkler heads to function to their full capability to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 1/14/2022 the Maintenance Supervisor/designee sealed the ceiling penetrations with a 1-hour fire rated material in the Memory Springs Pantry ceiling and around a metal conduit in the ceiling of the Memorial Springs Pantry to meet set standards. The Administrator verified the work on 1/17/2022 .	01/17/2022

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	Director agreed both holes in the Memory Springs Pantry were not properly fire stopped. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 1/14/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the ceiling is checked monthly for ceiling penetrations as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/17/2022.**	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders.	K 0511	**K511** – It is the intent of the facility to ensure wet locations are provided with GFCI protection against electric shock to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/14/2022the Maintenance Supervisor/designee replaced the electrical receptacle in the Memory Springs shower room (room 140) within two feet of the sink with GFCI receptacles to meet set standards. The	01/17/2022

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	(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities		Administrator verified the installation on 1/17/2022. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/14/2022 the Maintenance Supervisor/designee inspected all electrical outlets within six feet of sinks throughout the facility for GFCI outlets and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 1/14/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical outlets within six feet of sinks must be GFCI outlets to meet set standards. b. Maintenance Supervisor/designee will inspect all outlets within six feet of sinks monthly to ensure they remain working GFCI outlets as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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	(8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one resident and one staff person. Findings include: Based on observation on 01/04/22 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director from a sister facility, there was one electrical receptacle in the Memory Springs shower room (room 140) within two feet of the sink that were not provided with GFCI protection. The receptacle was tested with a GFCI testing device and it did not break the electrical circuit when tested. Based on interview at the time of observation, the Maintenance Director agreed the receptacle in the Memory Springs shower room was not properly GFCI protected. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/17/2022.**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of			

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	any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. This deficient practice could affect residents, staff and visitors while in the front entrance corridor which included staff offices, the Therapy Gym, and the Conference Room. Findings include: Based on observations on 01/04/22 between 1:30 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Director from a sister facility, the oxygen storage/transfer room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview at the time of observation, the Maintenance Director agreed the mechanically vented exhaust fan was not working. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage rooms where oxygen transferring takes place is provided with properly working mechanical ventilation to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/14/2022 the Maintenance Supervisor/designee repaired the mechanically vented exhaust fan in the oxygen storage/transfer room to meet set standards. The Administrator verified the repair on 1/17/2022 . 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 1/14/2022 the Maintenance Supervisor/designee inspected all Oxygen Storage and Transfilling Rooms and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 1/14/2022 the Administrator inserviced the Maintenance Supervisor/designee that the Oxygen Storage and	01/17/2022

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			Transfilling Rooms must be mechanically vented to meet set standards. b. Maintenance Supervisor/designee will test the exhaust fans in the Oxygen Storage and Transfilling Rooms weekly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/17/2022.	