PRINTED:	01/19/2022
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 01/04/2022 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 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 K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155494 B. WING 01/04/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 **NFPA 101** SS=E Exit Signage Bldg. 01 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 K 0293 K293- It is the intent of the 01/17/2022 failed to install proper exit signage at 1 of 11 doors facility to ensure to provide and that should be identified as an exit in the facility in maintain proper exit signage at accordance with LSC 7.10. LSC 7.10.1.2.1 exits, doors that should be identified as other than main exterior exit doors that obviously an exit in the facility to meet set PL0021 Page 2 of 12 Event ID: Facility ID: 000478 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/19/2022

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155494	(X2) MULTIPLE CO A. BUILDING B. WING	01 (X	3) DATE SURVEY COMPLETED 01/04/2022
	PROVIDER OR SUPPLIER		1350 N	address, city, state, zip cod I TODD DR FSBURG, IN 47170	
WAIER	S OF SCOTTSBUR	G, THE	3001		
(X4) ID		STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OI		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	tifiable as exits, shall be		standards.	
		oved sign that is readily visible		1.CORRECTIVE ACTIONS	
		of exit access. LSC 7.10.1.2.2			
		mponents of the egress path		1.On 1/14/2022 the	
		osure shall be marked by		Maintenance Supervisor/designe	e
		rectional exit signs where the egress path is not obvious.		installed an illuminated exit sign	
		ice could affect 21 residents		over the Memory Springs Unit Dining Room exit door to meet s	t
	and staff in the Mer			standards. The Administrator	el
		nory springs unit.		verified the work on 1/17/2022	
	Findings include:				
	Thinkings include.			2.ALL OTHERS WITH	
	Based on observation	ons on 01/04/22 between 1:30		POTENTIAL TO BE AFFECTED	
	p.m. and 3:30 p.m. during a tour of the			1.All residents and all staff	
		irector from a sister facility,		and visitors have the potential to	、
		nated EXIT sign over the		be affected but none were.	,
		nit Dining Room exit door. This		3.MEASURES TO PREVENT	
		s an exit door on the provided		REOCCURRENCE:	
		on interview at the time of		1.On 1/14/2022 the	
	-	aintenance Director agreed this		Administrator inserviced the	
		ed with an illuminated EXIT		Maintenance Supervisor/designe	ee
	sign above the door			on the requirement that all exits	
				must be identified with proper	
	This finding was re	viewed with the Maintenance		signage and a visual check mus	t
	Director and Admin	nistrator during the exit		be conducted on all exit lights,	
	conference.			signs, and all interior hallway	
				lights in all corridors and commo	on
	3.1-19(b)			areas weekly to include checkin	Ig
				for any burned-out bulbs and the	ose
				inspections must be documented	d
				on the Emergency-Powered	
				Lighting and Exit Signs Log to	
				meet set standards.	
				2.Maintenance	
				Supervisor/designee will conduc	ta
				visual check of all exit lights,	
				signs, and interior	
				hallway/common area lights	
				weekly and document those	
	1		1	inspection results on the	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 01/04/2022	
	PROVIDER OR SUPPLIE		1350 N	ADDRESS, CITY, STATE, ZIP COD			
WATERS	S OF SCOTTSBUR	RG, THE	SCOT	TSBURG, IN 47170			
(X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
				Emergency-Powered Lightin Exit Signs Log as a part of t facility's Preventive Mainten Program. If any issues are discovered, they will be add and resolved immediately. Maintenance Supervisor/de- will review with the Administ the inspection results. 3. The Administrator wi monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORREC ACTION: 1. The inspection result be presented by the Mainten Supervisor/designee to the Administrator monthly and t Administrator will present th inspection results at the mo Quality Assurance/Performa Improvement (QA/PI) meeti Inspection results and syste components will be reviewe the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained. This plan of correction constitutes our credible allegation of compliance w all regulatory requirements Our date of compliance is 1/17/2022.	he ance ressed The signee trator II CTIVE s will nance he e nthly ance ng. m d by ion d by ion d as re		

FORM CMS-2567(02-99) Previous Versions Obsolete

PL0O21 Facility ID: 000478

0478 If continu

If continuation sheet P

Page 4 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/04/2022 155494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, THE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0353 **NFPA 101** SS=B Sprinkler System - Maintenance and Testing Bldg. 01 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 K 0353 01/17/2022 Based on observation and interview, the facility K353 – It is the intent of the failed to ensure the ceiling in 1 of 7 sprinklered facility to ensure the ceiling in smoke compartments was maintained to allow sprinklered smoke compartments sprinkler heads to function to their full capability. are maintained to allow sprinkler This deficient practice could affect staff while in heads to function to their full the Memory Springs Pantry. capability to meet set standards. Findings include: **1.CORRECTIVE ACTIONS** TAKEN: Based on observations on 01/04/22 between 1:30 1.On 1/14/2022 the p.m. and 3:30 p.m. during a tour of the facility with Maintenance Supervisor/designee the Maintenance Director from a sister facility, sealed the ceiling penetrations there was a one inch hole with a TV cable in the with a 1-hour fire rated material in ceiling of the Memory Springs Pantry that was not the Memory Springs Pantry ceiling properly fire stopped, furthermore, there was a and around a metal conduit in the quarter inch hole around a metal conduit also in ceiling of the Memorial Springs the ceiling of the Memorial Springs Pantry that Pantry to meet set standards. was not properly fire stopped. Based on interview The Administrator verified the work at the time of each observation, the Maintenance on 1/17/2022. Event ID: PL0021 Facility ID: 000478 Page 5 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/19/2022

PRINTED:

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155494	A. BUILDING B. WING	<u>01</u>	COMPLETED 01/04/2022	
		100101			0 110 112022	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD I TODD DR		
VATER	S OF SCOTTSBUR	RG, THE		rodd dix rsburg, in 47170		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Director agreed bo	th holes in the Memory Springs		2.ALL OTHERS WITH		
	Pantry were not pr	operly fire stopped.		POTENTIAL TO BE AFFECTE	D:	
				1.All residents and all staf	ff	
	This finding was re	eviewed with the Maintenance		and visitors have the potential	to	
	Director and Admi	inistrator during the exit		be affected but none were.		
	conference.			3.MEASURES TO PREVENT		
				REOCCURRENCE:		
	3.1-19(b)			1.On 1/14/2022 the		
				Administrator inserviced the		
				Maintenance Supervisor/design	nee	
				on the requirement that the		
				sprinkler system must be		
				maintained to meet set standar	rds.	
				2.Maintenance		
				Supervisor/designee will ensur	e	
				the ceiling is checked monthly	for	
				ceiling penetrations as a part o	f	
				the facility's Preventive		
				Maintenance Program and		
				document those inspection res	ults	
				as appropriate. If any issues a	are	
				discovered, they will be addres	sed	
				and resolved immediately. The	e	
				Maintenance Supervisor/design	nee	
				will review with the Administrat	or	
				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 CORRECTIV		
				ACTION:		
				1.The inspection results w		
				be presented by the Maintenar	ice	
				Supervisor/designee to the		
				Administrator monthly and the		
				Administrator will present the	ь. —	
				inspection results at the month	iy 🔰	

	R MEDICARE & MEDIC		(VO)) (7 17 mm -	CONSTRUCTION	OMB NO. 0938-	
	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	ION NUMBER A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 01/04/2022	
	PROVIDER OR SUPPLIE		1350	T ADDRESS, CITY, STATE, ZIP COD N TODD DR ITSBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLE DATE	
				Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correctio developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance witt all regulatory requirements. Our date of compliance is 1/17/2022.	j. by n as	
< 0511 SS=D Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided 18.5.1.1, 19.5.1.1 Based on observati failed to ensure 1 of provided with grout (GFCI) protection 70, NEC 2011 Edit Circuit-Interrupter states, ground-fault personnel shall be 210.8(A) through (circuit-interrupter s accessible location Informational Note	I Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility f over 10 wet locations was nd fault circuit interrupter against electric shock. NFPA ion at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault shall be installed in a readily	K 0511	 K511 – It is the intent of the facility to ensure wet location are provided with GFCI protect against electric shock to meet standards. 1. CORRECTIVE ACTION TAKEN: a. On 1/14/2022the Maintenance Supervisor/desig replaced the electrical recepta in the Memory Springs showe room (room 140) within two fet the sink with GFCI receptacle meet set standards. The 	ction set set set gnee acle sr set of	

FERS FO	R MEDICARE & MEDI	UAID SERVICES			UM	B NO. 0938-039
ГАТЕМЕ	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPI	.ETED
		155494	B. WING		01/04	/2022
		D	STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE					
VATER	S OF SCOTTSBUR	(G, THE	SCOT	TSBURG, IN 47170		
(4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	_	(X5)
REFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		welling Units. All 125-volt,		Administrator verified the		
		and 20-ampere receptacles		installation on 1/17/2022.		
		ations specified in 210.8(B)(1)		2. ALL OTHERS WITH		
through (8) shall have ground-fault			POTENTIAL TO BE AFFEC			
	circuit-interrupter protection for personnel.			a. All residents and all st		
	(1) Bathrooms			and visitors have the potenti		
	(2) Kitchens			be affected but none were.	On	
	(3) Rooftops			1/14/2022 the Maintenance		
	(4) Outdoors			Supervisor/designee inspect		
	-	(3) and (4) : Receptacles that are		electrical outlets within six fe		
	•	ble and are supplied by a		sinks throughout the facility f		
		cated to electric snow-melting,		GFCI outlets and found no o	ther	
		e and vessel heating equipment		negative findings.		
	-	to be installed in accordance		3. MEASURES TO PREV	/ENT	
H c	with 426.28 or 427			REOCCURRENCE:		
	-	(4): In industrial establishments		a. On 1/14/2022 the		
	-	nditions of maintenance and		Administrator inserviced the		
	-	that only qualified personnel		Maintenance Supervisor/des	-	
		sured equipment grounding		on the requirement that elec		
		n as specified in 590.6(B)(2)		outlets within six feet of sinks		
	-	for only those receptacle		must be GFCI outlets to mee	et set	
		ply equipment that would		standards.		
	-	zard if power is interrupted or		b. Maintenance		
		at is not compatible with GFCI		Supervisor/designee will insp		
	protection.			all outlets within six feet of si		
		eceptacles are installed within		monthly to ensure they rema		
		outside edge of the sink.		working GFCI outlets as a pa	art of	
	•	(5): In industrial laboratories,		the facility's Preventive		
	-	supply equipment where		Maintenance Program and		
	_	would introduce a greater		document those inspection r		
	_	mitted to be installed without		as appropriate. If any issue		
	GFCI protection.			discovered, they will be addr		
	_	(5): For receptacles located in		and resolved immediately.		
	-	ns of general care or critical		Maintenance Supervisor/des	-	
		h care facilities other than those		will review with the Administ	ator	
	covered under	, , , , , , , , , , , ,		the inspection results.		
		protection shall not be required.		c. The Administrator will		
	(6) Indoor wet loca			monitor adherence to the		
		with associated showering		Preventative Maintenance		
	facilities			schedule and validate the		1

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155494	A. BUILDIN B. WING	G <u>01</u>	- 1	COMPLETED 01/04/2022	
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CO	DD		
WATER	S OF SCOTTSBUR	G, THE		OTTSBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAG	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETIO DATE	
	electrical diagnostic equipme NFPA 70, 517-20 receptacles and fix the wet location to interrupter (GFCI) reduce the contact electrical insulation This deficient prace and one staff person Findings include: Based on observation p.m. and 3:30 p.m. the Maintenance D there was one elect Springs shower root the sink that were the protection. The ree testing device and circuit when tested time of observation agreed the receptant shower room was the This finding was ree	et bays, and similar areas where ent, electrical hand tools. Wet Locations, requires all ed equipment within the area of have ground-fault circuit protection. Note: Moisture can resistance of the body, and n is more subject to failure. tice could affect one resident m. toon on 01/04/22 between 1:30 during a tour of the facility with birector from a sister facility, trical receptacle in the Memory om (room 140) within two feet of not provided with GFCI ceptacle was tested with a GFCI it did not break the electrical b. Based on interview at the n, the Maintenance Director ele in the Memory Springs not properly GFCI protected. eviewed with the Maintenance nistrator during the exit		Preventative Maintenan documentation is in pla 4. MONITORING CORRECTIVE ACTION a. The inspection re be presented by the Ma Supervisor/designee to Administrator monthly a Administrator will prese inspection results at the Quality Assurance/Perf Improvement (QA/PI) n Inspection results and a components will be rev the QA/PI Committee v subsequent plans of co developed and implement deemed necessary to e compliance is maintain This plan of correction constitutes our credib allegation of compliant all regulatory requirent Our date of compliant	ce. I: esults will aintenance the and the ent the e monthly formance neeting. system iewed by with prrection ented as ensure ed. n le ace with nents.		
(0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig	Transfilling Cylinders Transfilling Cylinders /gen from one cylinder to ordance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of					

PRINTED: 01/19/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
	or conduction	155494	B. WING	<u></u>	01/04/2022
		100101			0110112022
NAME OF	PROVIDER OR SUPPLIEF	ł		ADDRESS, CITY, STATE, ZIP COD	
				TODD DR	
WATER	S OF SCOTTSBUR	G, THE	SCOTI	ISBURG, IN 47170	
(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	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	prohibited in patie to liquid oxygen ca containers over 50 under 11.5.2.3.1 (liquid oxygen cont containers under 3 conditions under 4 11.5.2.2 (NFPA 99 Based on observation failed to ensure 1 of oxygen transferring with properly work This deficient pract and visitors while in which included staff and the Conference Findings include: Based on observation p.m. and 3:30 p.m. the Maintenance Di oxygen storage/trans a mechanically veri was not working at Based on interview Maintenance Direct vented exhaust fan This finding was re	on and interview, the facility f 1 oxygen storage room where takes place, was provided ing mechanical ventilation. ice could affect residents, staff in the front entrance corridor f offices, the Therapy Gym, Room. ons on 01/04/22 between 1:30 during a tour of the facility with rector from a sister facility, the isfer room was equipped with ted exhaust fan, however, it the time of observation. at the time of observation, the for agreed the mechanically	К 0927	K927– It is the intent of the fa to ensure oxygen storage roo where oxygen transferring tak place is provided with properf working mechanical ventilatio meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On 1/14/2022 the Maintenance Supervisor/desig repaired the mechanically ver exhaust fan in the oxygen storage/transfer room to meet standards. The Administrator verified the repair on 1/17/202 2. ALL OTHERS WITH POTENTAL TO BE AFFECTE a. All residents and all sta and visitors have the potentia be affected but none were. C 1/14/2022 the Maintenance Supervisor/designee inspecter Oxygen Storage and Transfill Rooms and found no other negative findings. 3. MEASURES TO PREV REOCCURRENCE: a. On 1/14/2022 the Administrator inserviced the Maintenance Supervisor/desig that the Oxygen Storage and	ms tes y n to IS gnee ted tset 22. ED: ff I to yn d all ing ENT

FORM CMS-2567(02-99) Previous Versions Obsolete

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/04/2022	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD I TODD DR		
WATERS	OF SCOTTSBUR	RG, THE		rsburg, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E (X5) COMPLET DATE	
	REGULATORY O	K LSC IDENTIFYTING INFORMATION		Transfilling Rooms must be mechanically vented to meet standards. b. Maintenance Supervisor/designee will test exhaust fans in the Oxygen Storage and Transfilling Roo weekly as a part of the facilit Preventive Maintenance Pro and document those inspect results as appropriate. If an issues are discovered, they addressed and resolved immediately. The Maintenar Supervisor/designee will revi 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 be presented by the Mainten Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performa Improvement (QA/PI) meetin Inspection results and syster components will be reviewed the QA/PI Committee with subsequent plans of correctin developed and implemented deemed necessary to insure compliance is maintained.	set the ms y's gram ion y will be nce iew will ance iew will ance iew iby nce iew	

PRINTED: 01/19/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039
	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 01/04/2022		
	ROVIDER OR SUPPLIER			1350 N	ADDRESS, CITY, STATE, ZIP COD TODD DR SBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ATE	(X5) COMPLETION DATE
					This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 1/17/2022.	h	

PL0021 Facility ID: 000478