PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155183		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD			(X3) DATE SURVEY COMPLETED 09/25/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE							
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	REGULATORT OR	LISC IDENTIFY IN OUT OR WATTON		TAU			DATE
E 0000	Department of Heal 483.73. Complaint Number deficiency related to 0007. Survey Date: 09/25 Facility Number: 00 Provider Number: 1002 At this Commplaint Martinsville was for Emergency Prepared Medicare and Medicand Suppliers, 42 Complaint to the survey, the censure Quality Review consumption of the survey	inducted by the Indiana th in accordance with 42 CFR IN00411970 - A Federal/State of the allegation was cited at E //23 00096 155183 290890 survey, The Waters of find not in compliance with dness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of us was 65. inpleted on 09/27/23 42 CFR, Subpart 483.73 is NOT	E 00	000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission and does not constitute an agreement with alleged deficiencies herein. The Plan Correction is submitted to meet the requirements established the state and federal regulation of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal substantial compliance with substantial compliance with substantial compliance with substantial compliance with substantial comp	of et by ns. the set	

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.

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

Broc

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Bennett

TITLE

(X6) DATE

10/09/2023

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155183 A. BUILDING B. WING		NSTRUCTION	COMPLETED 09/25/2023			
	PROVIDER OR SUPPLIER		2055 HE	ADDRESS, CITY, STATE, ZIP COD ERITAGE DR NSVILLE, IN 46151		
(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
E 0007 SS=E Bldg	403.748(a)(3), 416 441.184(a)(3), 482 483.73(a)(3), 484. 485.68(a)(3), 494. EP Program Patie §403.748(a)(3), §4 §441.184(a)(3), § §483.73(a)(3), §48 (3), §485.68(a)(3) §485.727(a)(3), §4 §494.62(a)(3). [(a) Emergency Pl develop and maint preparedness plar and updated at lea must do the follow (3) Address [patier including, but not I the type of service ability to provide in continuity of opera of authority and su *[For LTC facilities Emergency Plan. develop and maint preparedness plar and updated at lea must do all of the face (3) Address reside but not limited to, p services the LTC f provide in an emero operations, includi and succession plan and succession plan and succession plan	6.54(a)(3), 418.113(a)(3), 2.15(a)(3), 483.475(a)(3), 102(a)(3), 485.625(a)(3), 727(a)(3), 485.920(a)(3), 62(a)(3) Int Population Int 6.54(a)(3), §418.113(a)(3), Int 8.460.84(a)(3), §482.15(a)(3), Int 9.45.625(a)(3), Int 9.45.				

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	COMPLETED	
		155183	B. WING 09/25/2023			09/25/2023
NAME OF T	DOLUDED OF CURRY WA			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER			2055 H	ERITAGE DR	
	OF MARTINSVILL	E, THE		MARTII	NSVILLE, IN 46151	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		CELULA CODE CMCU		TAG	BEFEIENCT	DATE
	· ·	CE, HHA, CORF, CMCH,				
	RHC/FQHC, or ES	view, observation, and	l _E 0	007	DISCLAIMED STATEMENT.	10/00/2022
		ty failed to ensure the	E 0	007	DISCLAIMER STATEMENT:	10/09/2023
		dness plan addressed resident			Preparation and/or execution	11
		ng, but not limited to, persons			of this plan of correction in	
		services the LTC facility has			general, or this corrective	
		e in an emergency; and			action in particular, does no constitute an admission or	'
		ions, including delegations of			agreement by this facility of	tho
		ssion plans in accordance			facts alleged or conclusions	
	-	B(a)(3). This deficient practice			forth in this statement of	351
		residents, staff, and visitors.			deficiencies. The plan of	
	could affect over 20	residents, starr, and visitors.			correction and specific	
	Findings include:				corrective actions are prepa	rod
	i manigs merade.				and/or executed in compliar	
	Based on review of	the Administrator's			with state and federal laws.	
		or the facility's loss of the			This plan of correction	
		ee during record review with			constitutes a written allegati	ion
	-	he Environmental Director,			of substantial compliance w	
		e Director from 10:30 a.m. to			Federal Medicare and	
		5/23, the facility lost normal			Medicaid requirements.	
		ver for approximately, 6.5			E007 – It is the intent of the fa	ncility
		n. to 10:00 p.m. on 06/29/23 due			to ensure the emergency	,
	-	inderstorm on that date. The			preparedness plan addressed	ı
	_	ding power was transferred			resident population, including	
		arce to the facility's emergency			not limited to, person at-risk; t	
		e of the loss of power from the			type of services the LTC facili	l l
	_	ed on interview at the time of			has the ability to provide in ar	•
	record review, the A	Administrator, the			emergency; and continuity of	
	Environmental Dire	ector, and the Maintenance			operations, including delegati	ons
	Director stated all re	esident sleeping room outlet			of authority and succession p	
		receptacles are not supplied			in accordance with 42 CFR 48	33.73
	with electrical power	er from the facility's emergency			(a)(3) to meet set standards.	
		ninistrator, the Environmental			1 CORRECTIVE ACTIONS	s
		aintenance Director stated the			TAKEN:	
	facility has select or	utlet boxes in each corridor on			a On 10.09.2	023
	the emergency gene	erator. The Administrator, the			the Administrator	
	Environmental Dire	ector and the Maintenance			inserviced the Maintenance	
	Director stated exter	nsion cords are plugged into			Supervisor/designee not to us	se
the corridor outlet boxes and run into resident				extension cords as a substitut		

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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 B. WING 09/25/2023 155183 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2055 HERITAGE DR MARTINSVILLE, IN 46151 WATERS OF MARTINSVILLE. THE (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 sleeping rooms for residents requiring oxygen fixed wiring to meet set contractors, air mattresses or other medical standards. devices requiring electrical power during extended **ALL OTHERS WITH** power loss events such as the one that occurred POTENTIAL TO BE AFFECTED: on 06/29/23. Based on interview at the time of All residents and all staff and record review, the Environmental Director and the visitors have the potential to be Maintenance Director stated at least four affected but none were. extension cords are kept at each of the three **MEASURES TO PREVENT** nurse's stations to use for any medical devices REOCCURRENCE: requiring electrical power during normal source Maintenance power loss events. Based on observations with Supervisor/designee will ensure to the Maintenance Director at 11:10 a.m. on not use extension cords as a 06/29/23, one of the extension cords which would substitute for fixed wiring as a part be used in the event of normal source power loss of the facility's Preventive would not fit under the corridor door to resident Maintenance Program and sleeping room 18 when the door was in the closed document those inspection results and latched position due to the 3/8th's inch as appropriate. If any issues are clearance under the door as measured with the discovered, they will be addressed Maintenance Director's measuring tape. Based on and resolved immediately. The observations with the Environmental Director and Maintenance Supervisor/designee the Maintenance Director during a tour of the will review with the Administrator facility from 11:40 a.m. to 12:15 p.m., each resident the inspection results. sleeping room did not have outlet boxes on the The Administrator will emergency generator which would be identified monitor adherence to the with differentiated color markings than outlet Preventative Maintenance boxes solely on the normal source. Select red schedule and validate the outlet box cover plates and receptacles were Preventative Maintenance noted in each corridor. Based on interview at the documentation is in place. time of record review and of the observations, the

These findings were reviewed with the Administrator, the Environmental Director, and the Maintenance Director during the exit conference.

Administrator, the Environmental Director, and

services the LTC facility has the ability to provide

the Maintenance Director stated the type of

are enabled by the use of extension cords in

resident sleeping rooms in an emergency.

MONITORING CORRECTIVE ACTION:

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

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EPARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DAT			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A RUII DING	COMI			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIE S OF MARTINSVILI		2055 H	ADDRESS, CITY, STATE, ZIP COD IERITAGE DR NSVILLE, IN 46151		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
K 0000	This federal tag rel IN00411970.	ates to complaint number		the QA/PI Committee with subsequent plans of corredeveloped and implement deemed necessary to ensign compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance in 10.09.2023	ection ed as ure with nts.	
Bldg. 01	IN00411970 was c Department of Hea 483.90(a). Complaint Number deficiency related t K920. Survey Date: 09/2 Facility Number: 0 Provider Number: AIM Number: 100 At this Complaint s Martinsville was fo Requirements for F Medicare/Medicaic Life Safety from Fi National Fire Prote Life Safety Code (I	000096 155183 290890 survey, The Waters of bund not in compliance with	K 0000	The following Plan of Correctorstitutes the facility's we allegation of compliance for deficiency cited. However submission of this Plan of Correction is not an admission and does not constitute an agreement with alleged deficiencies herein. The formection is submitted to the requirements establish the state and federal regular preparation and/or exect of this plan of correction general, or this correctivn action in particular, does constitute an admission agreement by this facility facts alleged or conclusiforth in this statement of deficiencies. The plan of	ritten or the or the fr. ssion to or Plan of meet ned by lations. IT: ution in e s not or y of the ons set	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>01</u>			COMPLETED	
		155183	B. WI	B. WING 0		09/25/2	023
	PROVIDER OR SUPPLIER			2055 H	ADDRESS, CITY, STATE, ZIP COD ERITAGE DR NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0920 SS=E Bldg. 01	This one story facility Type V (111) construction The facility has a find detection in the corrider. The facility has a carensus of 65 at the total All areas where resist were sprinklered exished with customary. The facility has one providing facility structure facility has one providing facility structure. Quality Review consultation NFPA 101 Electrical Equipment Extens Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-related (PCREE) assembled by quant the conditions of 1 the patient care virunon-PCREE (e.g., except in long-terrido not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care recother UL standard used with general	atty was determined to be of ruction and fully sprinklered. The alarm system with smoke ridors and in all areas open to socility has battery operated all resident sleeping rooms. The apacity of 103 and had a clime of this visit. Indeed, the customary access cept for one detached smoking by access for resident smokers. The detached storage shed orage services which was not appleted on 09/27/23 The power Cords and the power care vicinity are only only and for the power care vicinity are only only and for the power care vicinity are only only and for the power care vicinity are only only and for the power care vicinity are only only and the power care vicinity are vicinity and vicinity and vicinity are vicinity and vicinity are vicinity and vicinity are vicinity and vicinity are vicinity and vi			corrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Facility respectfully request a desk review on E007 and K920. The facility requests a desk review.	on th	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155183		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/25/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 2055 HERITAGE DR MARTINSVILLE, IN 46151					
(X4) II PREFI TAC	X (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)	NTE .	(X5) COMPLETION DATE
	temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 9 (NFPA 70), 590.3 Based on record reinterview; the facilities to comply requires electrical with NFPA 70, Nate Edition. NFPA 70, unless specifically cables shall not be wiring of a structur building service eq for life safety shall approved in accord standards. NFPA 9 Facilities, 2012 edi as any portion of a patients are intended Patient care vicinity location intended for treatment of patient beyond the normal table, treadmill, or patient during exampatient care vicinity (2.3 m) above the form of they are not located they are not located.	re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 view, observation, and ity failed to ensure over 10 re not used as a substitute for ructure. LSC 19.5.1 requires with Section 9.1. LSC 9.1.2 viring and equipment to comply tional Electrical Code, 2011 Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed e. LSC Section 4.5.7 states any uipment or safeguard provided be designed, installed, and ance with all applicable NFPA 19, Standard for Health Care tion, defines patient care areas health care facility wherein and to be examined or treated. It is defined as a space, within a for the examination and tes, extending 6 ft (1.8 m) location of the bed, chair, other device that supports the mination and treatment. A received the exemplances are appliances not divide grounding conductors in the patient care eitent practice could affect over and visitors.	K 0	920	K920– It is the intent of the facto ensure extension cords are used as a substitute for fixed wiring of a structure to meet standards. 1 CORRECTIVE ACTIONS TAKEN: a On 10.09.20 the Administrator inserviced the Maintenance Supervisor/designee not to us extension cords as a substitute fixed wiring to meet set standards. 2 ALL OTHERS WITH POTENTAL TO BE AFFECTE a All residents and all staff visitors have the potential to be affected but none were. 3 MEASURES TO PREVER REOCCURRENCE: a Maintenance Supervisor/designee will ensure not use extension cords as a substitute for fixed wiring as a of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designee will review with the Administrative inspection results.	not et 023 ee e for ED: and ee NT re to part sults are ssed ne gnee	10/09/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155183		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIER		2055 H	ADDRESS, CITY, STATE, ZIP COD HERITAGE DR INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on review of handwritten notes for normal power source the Administrator, the Administrator, the Administrator, the Administrator, the Administrator, the Administrator, the Administrator and the Maintenance of the emergency generator at the time normal source. Based and the Administration of the emergency generator. The Administration of the emergency generator. The Administration of the emergency generator and the Maintenance of the corridor outlet be sleeping rooms for a concentrators, air material devices requiring eleptor of the emergency generator. The Administration of the corridor outlet be sleeping rooms for a concentrators, air material devices requiring eleptor of the Maintenance Director outlet be sleeping rooms for a concentrators, air material power loss events on 06/29/23. Based record review, the Famintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Administration of the Maintenance Director outlet be stationally the Mai	the Administrator's or the facility's loss of the e during record review with he Environmental Director, e Director from 10:30 a.m. to 1/23, the facility lost normal yer for approximately, 6.5 n. to 10:00 p.m. on 06/29/23 due anderstorm on that date. The ding power was transferred arce to the facility's emergency e of the loss of power from the ed on interview at the time of		b 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 w presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10.09.2023	ill be e hly ce g. by n as

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155183	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COMP	E SURVEY LETED 5/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2055 HERITAGE DR MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE		
	sleeping room 18 w and latched position clearance under the Maintenance Direct observations with the Maintenance Difacility from 11:40 sleeping room did remergency generate with differentiated boxes solely on the outlet box cover planoted in each corric propane fired emergoutside the building property which was interview and observation of the extension of the gap between the resident sleeping rodoor is in the fully one quarter inch gap Maintenance Direct noted in between the corridor door to when the door was position. These findings were Administrator, the laministrator, the laministrator Direct conference.	the corridor door to resident then the door was in the closed in due to the 3/8th's inch door as measured with the tor's measuring tape. Based on the Environmental Director and rector during a tour of the a.m. to 12:15 p.m., each resident to thave outlet boxes on the for which would be identified color markings than outlet mormal source. Select reducts and receptacles were dor. The facility has one gency generator located gon the northeast side of the arated at 40 kW. Based on exitions during the exit artist could be run in between the door frame and the face of a come corridor door when the colosed and latched position. A power parameter was a door frame and the face of resident sleeping room 16 in the fully closed and latched ereviewed with the tenvironmental Director, and rector during the exit these to complaint number the states and states and states and number the states and number the states and number the sta						

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CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	D 110. 0750-057
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01		COMPLETED	
		155183	B. WING		·	09/25/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2055 HERITAGE DR				
WATERS OF MARTINSVILLE, THE				MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
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