CE.TERS TOR	THE CONTENTS	SERVICES				0.11	21.0.0,000
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING		COMPL	ETED
		155556	B. WIN	G		03/21/	/2024
		<u> </u>	- - 	CTDEET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹					
WATERS	OF TIPTON SKILI	LED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BI	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE	DATE
E 0000							
Bldg							
Ŭ	An Emergency Pre	paredness Survey was	E 000	00			
		ndiana Department of Health in					
	accordance with 42	-					
	Survey Date: 03/21	1/24					
	Facility Number: 00						
	Provider Number: 1						
	AIM Number: 100266350 At this Emergency Preparedness survey, The Waters of Tipton Skilled Nursing Facility was found in compliance with Emergency						
	-	irements for Medicare and					
		ting Providers and Suppliers, 42					
	-	acility has a capacity of 150 and					
		at the time of this survey.					
	nad a census of 67 t	at the time of this survey.					
	Quality Review cor	mpleted on 03/22/24					
K 0000							
Bldg. 01							
	-	Recertification and State	K 00	00			
		vas conducted by the Indiana					
	_	Ith in accordance with 42 CFR					
	483.90(a).						
	Survey Date: 03/21	1/24					
	Sarvey Date. 03/21	1/27					
	Facility Number: 0	000505					
	Provider Number: 1						
	AIM Number: 1002	266350					
	At this Life Safety	Code survey, The Waters of					
	Tipton Skilled Nurs	sing Facility was found not in					
	compliance with Re	equirements for Participation in					
							<u> </u>
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		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.

> Event ID: 0RTB21

Facility ID:

Administrator

000505 If continuation sheet 04/16/2024

Victoria Roe

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/21/2024	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD NRGROUNDS RD N, IN 46072	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 0341 SS=F Bldg. 01	Medicare/Medicaid. Life Safety from Fir National Fire Protect Life Safety Code (L. Health Care Occupated) This two story facility on the corridors and detectors in the residuality has a capacing at the time of this access were sprinkle facility services were sprinkled facility services were sprin	residents have customary ered. All areas providing re sprinklered. Inpleted on 03/22/24 In - Installation In - Installation In is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment. Wiring or other is are monitored for	K 0341	Preparation and/or executio	on 04/21/2024

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

Event ID:

0RTB21

Facility ID: 000505

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155556	B. W	ING	03/21/2024		
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>	300 FAIRGROUNDS RD				
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE	TIPTON, IN 46072				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X.	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DAT	E
	failed to ensure 2 of 2 fire alarm control units, located in an area that was not continuously				of this plan of correction in		
		-			general, or this corrective		
		ided with annunciation readily adding personnel to facilitate an			action, does not constitute a		
	_	o the fire situation. LSC 9.6.1.3			admission or agreement by		
		r system to be installed, tested,			facility of the facts alleged o		
	_	ccordance with NFPA 70,			conclusions set forth in this		
		Code and NFPA 72, National			statement of deficiencies. T		
					plan of correction and speci		
	Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 10.16.3.1 states all required				corrective actions are prepa		
		-			and/or executed in complian with state and federal laws.	ce	
annunciation means shall be readily accessible to responding personnel. Section 10.16.3.2 states all							
required annunciation means shall be located as					This plan of correction		
	required annunciation means shall be located as required by the authority having jurisdiction to				constitutes a written allegati		
		at response to the fire situation.			of substantial compliance will Federal Medicare and	tn	
		tes the trouble signal(s) shall be					
		- · · · ·			Medicaid requirements.		
	located in an area w	where it is likely to be heard.			It is the intent of the facility to		
	Ammor A is not a ma	out of the magninements but is			ensure fire alarm control units		
	_	art of the requirements but is			located in an area that was no		
		ational purposes only			continuously occupied, is prov	laea	
		tates the primary purpose of			with annunciation readily		
	I -	nnunciation is to enable			accessible to responding	1	
		el to identify the location of a			personnel to facilitate an effici		
		curately and to indicate the			response to the fire situation t	9	
		r equipment or fire safety			meet set standards.		
	occupants in a fire s	t affect the safety of			CORRECTIVE ACTIONS TAK		
		ice could affect all patients,			The facility will have the fire p		
	staff and visitors in	•			relocated on 4/19/2024 to an a	I	
	Stall and Visitors in	uie facility.			that is visible to a nurses station that is staffed at all hours.	ווע	
	Findings include:				ALL OTHERS WITH POTENT		
	Findings include:				TO BE AFFECTED:	IAL	
	Rased on observation	ons with the Maintenance			All residents and all staff and		
		lministrator on 03/21/24 at 2:40			visitors have the potential to b		
		alarm control unit was in the			affected but none were.	`	
	1 -				MEASURES TO PREVENT		
	mechanical room and a remote annunciator was in the front foyer. Both areas are only occupied				REOCCURRENCE:		
		ars and not continuously			The fire panel will be located i	n an	
	_	instand not continuously interview at the time of the			•		
	1 -	D agreed the main panel and			area of the facility that is staffe	u	
	L OOSELVALIOUS, THE IVI	i aziccu nic mam Danci and			1 /4/1	1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COME	E SURVEY PLETED 1/2024		
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	occupied and stated annunciator in the c the building.	ontinuously occupied areas of iewed with the Administrator		MONITORING CORE ACTION: The inspection result presented by the DO staff/designee to the monthly and the Adm present the inspectio the monthly Quality Assurance/Performan Improvement (QA/PI) Inspection results and components will be refered to the QA/PI Committees subsequent plans of developed and impled deemed necessary to compliance is mainta This plan of correctionstitutes our creditallegation of complia all regulatory requir Our date of complia 4/21/2024.	s will be N/nursing Administrator ninistrator will n results at nce) meeting. d system eviewed by with correction mented as o ensure nined. ion dible ance with ements.			
K 0353 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	<u> </u>						

PRINTED: 04/18/2024 FORM APPROVED

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE WATERS OF TIPTON SKILLED NURSING FACILITY, THE RECOLLATORY OR LSC IDENTIFYING INFORMATION Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler systems in accordance with 19.33.3. NPPA 25 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.33.3. NPPA 25, 2011 Edition, 14-2.1 states except as discussed in 14-2.1.1 and 14-2.1.4 and is specified or priping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03/21/24 of 12.30 p.m., the internal inspection of priping documentation was not available for review. Based on interview at the time of record review with the Maintenance Director (MD) on 03/21/24 of 12.30 p.m., the internal inspection of priping documentation was not available for review. Based on interview at the time of record review with the Maintenance Director (MD) on 03/21/24 of 12.30 p.m., the internal inspection and priping documentation was not available for review. Based on interview at the time of record review with the Administratur and MD at the exit conference. 3.1-10(h) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet sprinkler system are provided with sparse sprinklers, as pare sprinkler cabinet large enough to fit all sparse sprinkler cabinet large enough to fit all sparse sprinkler cabinet large enough to fit all sparse sprinkler combined large enough to fit all sparse sprinkler combined large enough to fit all sparse sprinkler combined large enough to fit and the cabinet large eno	JENTERS F	OR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE SIMMARY STATIMANY OF DEPENDENCE (CA) ID SIMMARY STATIMANY OF DEPENDENCE TAG 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 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 stard sexpection of priping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03.21/24 at 12:30 p.m., the intermal inspection of piping documentation was not available for review. Based on interview at the time of record review, the MD agreed the internal inspection of piping documentation was not available for review. There was a 5 year internal pipe inspection tage on the riser that was dated 4/14/18 which is over 5 years old. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to casure 1 of 1 wet sprinkler system was provided with spare sprinklers, a spare sprinkler conference was provided with spare sprinkler internal pipe inspection to meet set standards.	STATEM	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, N 46072 SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.77, 9.78, and NFPA 25 1. Based on record review and miterview, the facility of the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03/21/24 at 12:30 p.m., the internal inspection of piping documentation was not available for review. There was a 5 year internal pipe inspection tog on the irser that was dated 4/14/18 which is over 5 years old. STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 IPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072 A PROVIDEMENT AND SHOULDER ADDRESS CITY, STATE, ZIP COD 300 FAIR CITY ADDRESS CITY, STATE, ZIP CAD 300	AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
WATERS OF TIPTON SKILLED NURSING FACILITY, THE TO SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler systems in accordance with 19.5.3. NPA 25. 25. 11 Based on record review and interview, the fiscility failed to maintain 2 of 2 sprinkler systems in accordance with 19.5.3. NPA 25. 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 032/12/4 at 12.30 p.m., the internal inspection of piping domentation was not available for review. There was a 5 year internal pipe inspection documentation was not available for review. There was a 5 year internal pipe inspection documentation was not available for review. There was a 5 year internal pipe inspection and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet sprinkler system was provided with sparse sprinklers, a spare sprinkler leads, and a sprinkler contractor will complete the 5 year internal pipe inspection to meet set standards.			155556	B. WING		03/21/2024	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line contditions shall be conducted every 5 years by opening a flushing connection at the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03/21/24 at 12:30 p.m., the internal inspection of piping documentation was not available for review. Based on interview at the time of record review, the MD agreed the internal inspection documentation was not available for review. There was a 5 year internal pipe inspection to commentation was not available for review. There was a 5 year internal pipe inspection to commentation was not available for review. There was a 5 year internal pipe inspection to commentation was not available for review. There was a 5 year internal pipe inspection to meet set standards. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinkler town the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinkler town the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinkler town the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinkler town the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and/or execution of this plan of correction in general, or this con	WATER	RS OF TIPTON SKILL	LED NURSING FACILITY, THE	300 FA TIPTOI	IRGROUNDS RD		
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 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1.4 am inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 03/21/24 at 12:30 p.m., the internal inspection of piping documentation was not available for review. Based on interview at the time of record review, the MD agreed the internal inspection documentation was not available for review. There was a 5 year internal pipe inspection tag on the riser that was dated 4/14/18 which is over 5 years old. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet sprinkler system was provided with spare sprinklers, a spare inspection to meet set standards.	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
	TAU	Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record facility failed to main accordance with Edition, 14.2.1 state 14.2.1.1 and 14.2.1.1 branch line conditions years by opening a of one main and by the end of one branch inspecting for the prinorganic material. affect all occupants Findings include: Based on record review Director (MD) on 00 internal inspection of not available for review inspection documer review. There was inspection tag on the which is over 5 year. This finding was reand MD at the exit of 3.1-19(b) 2. Based on observe facility failed to enswas provided with sever severe and was provided with severe and was provid	RKS information on non-required or partial er system. , and NFPA 25 review and interview, the sintain 2 of 2 sprinkler systems 19.3.5.3. NFPA 25, 2011 es except as discussed in .4 an inspection of piping and ons shall be conducted every 5 flushing connection at the end removing a sprinkler toward ch line for the purpose of resence of foreign organic and This deficient practice could . View with the Maintenance 13/21/24 at 12:30 p.m., the of piping documentation was view. Based on interview at the ew, the MD agreed the internal nation was not available for a 5 year internal pipe he riser that was dated 4/14/18 rs old. Viewed with the Administrator conference.		Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by a facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific 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. It is the intent of the facility to ensure to maintain sprinkler systems in accordance with 19.3.5.3 and to ensure wet sprinkler systems are provided with spare sprinklers, a spare sprinkler cabinet large enough fit all spare sprinkler heads, as sprinkler wrench on the premit to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 4/16/2024 the facility licensed sprinkler contractor we complete the 5 year internal present the statement of the security of the sec	n 04/16/2024 In this r he fic red ce on ith d a ses ties will ipe rds.	

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sprinkler heads, and a sprinkler wrench on the

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work on 4/17/2024.

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		î ´	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155556	B. WING		03/21/2024	
NAME OF F	PROVIDER OR SUPPLIEF	3		T ADDRESS, CITY, STATE, ZIP COD		
				AIRGROUNDS RD		
WATERS	S OF TIPTON SKILI	LED NURSING FACILITY, THE	TIPTO	DN, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1 ~	5, Standard for the Inspection,		2.On 04/04/2024 the		
	_	enance of Water-Based Fire		Maintenance Supervisor will		
	1	, 2011 Edition, Section 5.4.1.4		ensure to have all types of sp	are	
		pare sprinklers (never fewer		sprinkler heads in the spare		
	· ·	naintained on the premises so		sprinkler cabinet that are utilize	zed	
		that have been operated or		in the facility to meet set		
		y can be promptly replaced.		standards. The Administrator	ſ	
	_	l correspond to the types and		verified this on 4/4/2024.		
		of the sprinklers on the		2.ALL OTHERS WITH		
		nklers shall be kept in a cabinet		POTENTIAL TO BE AFFECT		
located where the temperature in which they are				1.All residents and all st		
subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be			and visitors have the potential be affected but none were.	11 10		
		n the cabinet to be used in the		3.MEASURES TO PREVEN	IT.	
		ation of sprinklers. This		REOCCURRENCE:	11	
		ould affect all residents and		1.On 04/04/2024 the		
	staff in the facility.			Administrator in serviced the		
	starr in the racinty.			Maintenance Supervisor/desi	anee	
	Findings include:			on the requirement to maintain	-	
	i maniga matawa.			sprinkler systems and to ensu	I	
	Based on observation	on with the MD on 03/21/24 at		the spare sprinkler cabinet ha		
	3:05 p.m., the 2 spa	are sprinkler cabinets in the riser		types of spare sprinkler head		
		le ordinary (red liquid) pendant		utilized in the facility to meet		
	sprinkler heads. Du	uring the facility tour there		standards.		
	were many ordinary	y pendant sprinkler heads		2.Maintenance		
	throughout the facil	lity. Based on interview at the		Supervisor/designee will ensu	ure to	
		tions, the Maintenance		maintain sprinkler systems ar	nd to	
		spare sprinkler cabinet did not		ensure the spare sprinkler ca	binet	
	contain all types of	spare sprinkler heads utilized		has all types of spare sprinkle	er e	
	in the facility.			heads utilized in the facility as	s a	
				part of the facility's Monthly		
		viewed with the Maintenance		Preventive Maintenance Prog	•	
		nistrator during the exit		and document those inspection	I	
	conference.			results as appropriate. If any		
	2.1.10(1)			issues are discovered, they w	/III be	
	3.1-19(b)			addressed and resolved		
				immediately. The Maintenan	I	
				Supervisor/designee will revie	€W	
				with the Administrator the		
	Ī		1	inspection results.	l	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/21/2024
	PROVIDER OR SUPPLIE S OF TIPTON SKILI	LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD N, IN 46072	
(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)	(X5) COMPLETION DATE
				3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECT ACTION: 1.The inspection results be presented by the Maintena 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 a 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 04/16/2024.	will ance hly ce g. by
K 0363 SS=E Bldg. 01	than required encexits, or hazardou of smoke and are solid-bonded core capable of resistir	corridor openings in other losures of vertical openings, as areas resist the passage made of 1 3/4 inch wood or other material ag fire for at least 20 fully sprinklered smoke			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BUILDING 01 B. WING		COMPLETED 03/21/2024			
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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		
	passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary such flammable or combustible of combustib	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Dutch doors are permitted. Door compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments citions in area or fire as or frames in window Parts 403, 418, 460, 482, as details of doors such as ags, automatics closing	W 03/2		04/09/2024		
	failed to ensure 2 co with a means suitab had no impediment	on and interview, the facility orridor doors were provided le for keeping the door closed, to closing, latching and would smoke. This deficient t 4 residents.	K 0363	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by t facility of the facts alleged or conclusions set forth in this	n his		

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If continuation sheet

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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 03/21/2024 155556 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 FAIRGROUNDS RD WATERS OF TIPTON SKILLED NURSING FACILITY, THE **TIPTON. IN 46072** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: statement of deficiencies. The plan of correction and specific Based on observation with the Administrator and corrective actions are prepared Maintenance Director (MD) on 03/21/24 at 2:00 and/or executed in compliance p.m. and 3:00 p.m., the corridor door to resident with state and federal laws. sleeping room 28 and 69 would not close and latch This plan of correction into the frame when tested. Based on interview at constitutes a written allegation the time of observation, the MD agreed the of substantial compliance with corridor door to room 28 and 69 would not close **Federal Medicare and** and latch into the door frame. Medicaid requirements. It is the intent of the facility to These findings were reviewed with the ensure corridor doors are provided Administrator and MD during the exit conference. with a means suitable for keeping the door closed, have no 3.1-19(b) impediments to closing, latching and would resist the passage of smoke to meet set standards. **CORRECTIVE ACTIONS** TAKEN: On 3/21/2024 the Maintenance Supervisor/designee repaired the corridor door to resident sleeping room 28 & 69 to ensure the doors fully close and latch into the frame to meet set standards. The Administrator verified the repairs on 3/22/2024. **ALL OTHERS WITH** POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they close and latch into the frame and found no other negative findings. **MEASURES TO PREVENT** REOCCURRENCE:

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On 04/04/2024 the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC					OM	B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/21/2024	
		155556					
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	•	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Administrator in serviced the Maintenance Supervisor/design on the requirement that corrid doors must fully close and late into the frame to meet set standards. b Maintenance Supervisor/designee will inspeall corridor doors throughout the facility monthly to ensure they fully close and latch into the frasian apart of the facility's Preventance 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 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 were be presented by the Maintenance supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system	gnee or ch ect he same entive sults are ssed he gnee stor	DATE
					be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performan Improvement (QA/PI) meeting	nce hly ce J.	

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the QA/PI Committee with subsequent plans of correction

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-039				
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155556	B. WING 03/21/2024			/2024	
NAME OF I	DROLUDED OD GLIDDLIEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI			300 FA	IRGROUNDS RD		
WATERS	OF TIPTON SKIL	LED NURSING FACILITY, THE		TIPTON	N, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT.			(X5)
PREFIX	(EACH DEFICIEN	ICY 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
					developed and implemented a	IS	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible	-	
					allegation of compliance with	a	
					all regulatory requirements.		
					Our date of compliance is 04/8/2024		
					04/8/2024		
K 0372	NFPA 101						
SS=E	-	ilding Spaces - Smoke					
Bldg. 01	Barrie	3 1					
-	Subdivision of Bu	ilding Spaces - Smoke					
	Barrier Constructi						
	2012 EXISTING						
	Smoke barriers sh	nall be constructed to a					
	1/2-hour fire resis	tance rating per 8.5. Smoke					
	barriers shall be p	permitted to terminate at an					
	atrium wall. Smok	e dampers are not required					
	in duct penetration	ns in fully ducted HVAC					
	systems where ar	n approved sprinkler system					
	is installed for sm	oke compartments adjacent					
	to the smoke barr						
	19.3.7.3, 8.6.7.1(,					
	1	chanical smoke control					
	system in REMAF						
		on and interview, the facility	K 0	372	Preparation and/or execution	1	04/08/2024
	_	netrations through 1 of 8 smoke			of this plan of correction in		
	_	rotected to maintain the smoke			general, or this corrective		
		moke barrier. LSC Section			action, does not constitute a		
		noke barriers to be constructed			admission or agreement by t		
		LSC Section 8.5 and shall have			facility of the facts alleged of	Γ	
		fire resistive rating. LSC			conclusions set forth in this	h.a.	
		uires smoke barriers to be outside			statement of deficiencies. The plan of correction and appoint	-	
					plan of correction and specif		
		o a floor, or from a smoke barrier or by use of a combination			corrective actions are prepar		
	io a smoke parrier,	or by use of a combination	1		and/or executed in complian	CE	I

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thereof. 8.5.6.2 requires penetrations for cables,

cable trays, conduits, pipes, tubes, vents, wires,

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with state and federal laws.

This plan of correction

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155556	B. W	ING		03/21/	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			JRGROUNDS RD		
WATERS	S OF TIPTON SKILI	LED NURSING FACILITY, THE			N, IN 46072		
	1		1		1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION and similar items to accommodate electrical,			TAG			DATE
					constitutes a written allegati		
		ing, and communications			of substantial compliance w	ith	
		nrough a wall, floor, or			Federal Medicare and		
	1	bly constructed as a smoke			Medicaid requirements.		
	_	the ceiling membrane of the toke barrier assembly, shall be			It is the intent of the facility to		
	1	em or material capable of			ensure penetrations through		
		ement of smoke. This deficient			smoke barrier walls are protect to maintain the smoke resistate		
	_	et staff and at least 20 residents					
	in two smoke comp				of each smoke barrier to meet	. set	
	in two smoke comp	oartments.			standards. 1 CORRECTIVE ACTIONS	-	
	Findings include:				1 CORRECTIVE ACTIONS	>	
	rindings include.				a On 03/22/2024 the		
	Rosed on observative	on with the Maintenance				anoo	
		03/21/24 at 3:20 p.m., the smoke			Maintenance Supervisor/design sealed the 3/4 inch gap in the	-	
		the smoke barrier doors by the			smoke barrier wall above the		
		nere was a 3/4 inch gap around			smoke barrier doors by the		
		conduit. Based on interview at			conference room with a one h	our	
	_	tion, the MD agreed there was			fire rated material to meet set		
		penetration in the smoke			standards. The Administrator		
		noke barrier doors by the			verified the work on		
	conference room.	noke barrier doors by the			03/22/2024.		
	conference room.				2 ALL OTHERS WITH		
	The finding was rev	viewed with the MD and the			POTENTIAL TO BE AFFECTI	ED:	
	1	ng the exit conference.			a All residents and all staf		
		is the oat comercine.			and visitors have the potential		
	3.1-19(b)				be affected but none were. O		
					3/22/2024 the Maintenance	••	
					Supervisor/designee inspecte	d all	
					smoke barrier walls and ceilin		
					throughout the facility for	9-	
					penetrations and found no oth	ıer	
					negative findings.		
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a On 04/04/2024		
					Administrator in serviced the		
					Maintenance Supervisor/design	nee	
					on the requirement that smoke		
					barriers walls are constructed		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 03/21	LETED
	ROVIDER OR SUPPLIE	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IIRGROUNDS RD N, IN 46072)	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
				provide at least a one har resistance rating and ceil must be free from penetral meet set standards. b Maintenance Supervisor/designee will all smoke barrier walls ar ceilings throughout the far monthly to ensure they refree of penetrations as a the facility's Preventive Maintenance Program ar document those inspection as appropriate. If any is discovered, they will be a and resolved immediately Maintenance Supervisor/will review with the Admintenance Supervisor/will review with the Admintenance Supervisor/will review Maintenance to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place 4 MONITORING CORRECTIVE ACTION: a The inspection results are the presented by the Maintenance of the Preventative Maintenance documentation is in place 4 MONITORING CORRECTIVE ACTION: a The inspection results and synchronic results at the respection results at the respection results and synchronic results and synchr	ings ations to inspect ad acility emain part of ad on results sues are addressed y. The designee nistrator will ace ace act the monthly mance acting. stem wed by h ection	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING O1 COMPLETED COMPLETED					
		155556	B. WING 03/21/2024				2024
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE				300 FAI	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD I, IN 46072		
(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)	TE	(X5) COMPLETION DATE
					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 04/08/2024.	1	
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 20 ground fault circuit interrupter (GFCI) was properly maintained for 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. This deficient practice could affect 3 residents. Findings include: Based on observation with the Maintenance Director (MD) on 03/21/24 at 2:55 p.m. when the GFCI receptacle located within 6 feet feet from the sink in the Aviary kitchenette was tested with a GFCI tester the electric receptacle did not trip. Based on interview at the time of observation, the MD agreed the GFCI electric receptacle within 6		K 0:	511	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific 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. It is the intent of the facility to ensure ground fault circuit interrupter (GFCI) is properly maintained for protection again	n his ne fic red ce	04/08/2024

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/21/2024
		300 FA	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD N, IN 46072		
PREFI	X (EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) E COMPLETION DATE
	and the MD during			electric shock to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: A. On 3/21/2024 the Maintenance Supervisor rep the GFCI receptacle located Aviary Kitchenette to meet set standards. The Administrate verified the work on 3/22/2021. ALL OTHERS WITH POTENTIAL TO BE AFFECT 1.All residents and all stand visitors have the potentiable affected but none were. 2.MEASURES TO PREVEINGE 1.On 04/04/2024 the Administrator inserviced the Maintenance Supervisor/desion the requirement to ensure GFCI receptacles are proper maintained for protection again electric shock to meet set standards. 2.Maintenance Supervisor/designee will ensure GFCI receptacles are proper maintained for protection again electric shock as a part of the facility's monthly Preventive Maintenance Program and document those inspection ras appropriate. If any issue discovered, they will be addrand resolved immediately. The Maintenance Supervisor/designer will review with the Administrator will review with the Administrator will review with the Administrator will supervisor results. 3.The Administrator will	elaced in the et or 224. TED: staff al to NT signee e all rly ainst e results es are ressed The signee rator

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/21/2024			
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	LECTION (X5) OULD BE PROPRIATE DATE			
				monitor adherence to the Preventative Maintenary schedule and validate the Preventative Maintenary schedule and validate the Preventative Maintenary documentation is in plath 3.MONITORING CORNICTORING CORNICTORIO CORNICTOR	nce he nce ce. RRECTIVE esults will aintenance the and the ent the emonthly formance neeting. system iewed by vith rrection ented as ensure ed. I le ice with nents.			
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155556		155556	B. WING 03/2			03/21	/2024
		1		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					IRGROUNDS RD		
WATERS OF TIPTON SKILLED NURSING FACILITY, THE					N, IN 46072		
					1,		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		O SMOKING or shall be					
	= -	ternational symbol for no					
	smoking.						
	, ,	occupancies where					
	smoking is prohibi	_					
		d at all major entrances,					
		vith language that prohibits					
	smoking shall not						
	, ,	atients classified as not					
	responsible shall I	pe pronibiled. ent of 18.7.4(3) shall not					
	• •	atient is under direct					
	supervision.	atient is under direct					
	(5) Ashtrays of noncombustible material and						
	, ,	be provided in all areas					
	-	-					
	where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied						
		vailable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4						
		on and interview; the facility	K0	K 0741 Preparation and/or		า	04/08/2024
	failed to ensure 2 of	f 3 smoking areas were			of this plan of correction in		
	maintained by dispo	osing cigarette butts in a metal			general, or this corrective		
	or noncombustible	container with self-closing			action, does not constitute a	n	
	cover devices. This	deficient practice could affect			admission or agreement by t	his	
	staff and 6 residents	s and staff in the smoking			facility of the facts alleged or	r	
	areas.				conclusions set forth in this		
					statement of deficiencies. T	he	
	Findings include:				plan of correction and specific corrective actions are prepared		
	Based on observation during a tour of the facility						
					and/or executed in complian	ce	
		ce Director (MD) and			with state and federal laws.		
	Administrator on 03/21/24 at 2:20 p.m., in two of the smoking areas, there were over 30 cigarette				This plan of correction		
					constitutes a written allegati		
	•	ne ground in and around the			of substantial compliance wi	ith	
		ne front entrance and by door			Federal Medicare and		
		ew at the time of observations,			Medicaid requirements.		
		irector agreed there were			It is the intent of the facility to		
cigarette butts on the ground in the		1		ensure smoking areas are		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 03/21/2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WATERS OF TIPTON SKILLED NURSING FACILITY, THE				IRGROUNDS RD N, IN 46072			
(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)	TE	COMPLETION
TAG	aforementioned loca	LSC IDENTIFYING INFORMATION		TAG		otto	DATE
	aforementioned foca	ations.			maintained by disposing cigar butts in a metal or noncombus		
	This finding was re	viewed with the Administrator			container with self-closing cov		
		irector during the exit		devices to meet set sta			
	conference.				1 CORRECTIVE ACTIONS	3	
					TAKEN:		
	3.1-19(b)				a On 3/21/2024 the		
					Administrator/DON/Maintenar		
					Supervisor/designee removed cigarette butts from the ground		
					and around the smoking areas		
					the front entrance and by door	-	
					meet set standards. The		
					Administrator verified the work	c on	
					3/22/2024 .		
					2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTI		
					a All residents and all staf		
					and visitors have the potential be affected but none were.	το	
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a On 04/04/2024 the		
					Administrator in serviced all st	aff	
					on the requirement to ensure		
					metal containers with self-clos	_	
					lids are located in smoking are	eas	
					to meet set standards.		
					b Maintenance Supervisor/designee will ensu	re	
					metal containers with self-clos		
					lids are present in all smoking	_	
					areas per the facility's Smokin		
					Policy and document those	-	
					inspection results as appropri	ate.	
					If any issues are discovered, t	-	
					will be addressed and resolve		
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					I WILL THE AUMINISTRATOR THE		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED			
155556			B. WING 03/21/2024				
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			300 FAI	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD , IN 46072			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PH	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY	AC LISC IDENTIFICATION ORNIGATION			inspection results. c The Administrator will monitor adherence to the Smot Policy and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintenan Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant 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 a 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 04/08/024	ill nce hly ce by	DAIL

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