STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/01/22 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270 At this Emergency Preparedness survey, The Waters of Indianapolis was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 81 certified beds. At the time of the survey, the census was 72. Quality Review completed on 09/06/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey completed on September 1, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. We respectfully request a desk review.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 8:35 a.m. to 11:15 a.m. on 09/01/22, thirty-six month period emergency generator testing documentation for four continuous hours for the natural gas fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one natural gas fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the facility has one natural gas fired emergency generator located inside the Maintenance Office near the south exit door for the facility. The manufacturer's nameplate rating for the generator could not be determined. This finding was reviewed with the Administrator and the Maintenance Director during the exit	E 0041	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee conducted the thirty six month period emergency generator test for four continuous hours and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that a thirty six month period emergency generator test for four continuous hours must be conducted on the facilities emergency generator every three years to meet set standards. b. The Maintenance Supervisor/designee will ensure a thirty-six-month period emergency generator test for four continuous hours is conducted every three years and documented in the life safety binder to meet set	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference.		standards. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/01/22 Facility Number: 000537 Provider Number: 155409	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AIM Number: 100267270 At this Life Safety Code survey, The Waters of Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 81 and had a census of 72 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage and a detached smoking shed which were each not sprinklered. Quality Review completed on 09/06/22		required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey completed on September 1, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. We respectfully request a desk review.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 2 entrance doors to the Main Dining Room and	K 0100	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to install and maintain a door closing coordinator for doors in 1 of 1 door sets to the Main Dining which are equipped with an astragal per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the Main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the latching hardware on the door frame for the west door in the corridor door set serving as the entrance to the Main Dining Room by the center nurse's station was removed and not in place to allow the latching mechanism on the door to latch into the door frame. In addition, the west door in the door set was also equipped with an astragal but the door set was not provided with a door closing coordinator to ensure the door equipped with the astragal always closes last. Each door in the door set was held in the open position with a wall mounted magnetic releasing device set to release with fire alarm system activation. Based on interview at the time of the observations, the Maintenance Director agreed the west door in the door set had missing latching hardware on the door frame and the door set was not equipped with a door closing coordinator. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Supervisor/designee installed the latching hardware on the door frame for the west door in the corridor door set serving as the entrance to the Main Dining Room to allow the door to latch into the door frame. The maintenance supervisor/designee also installed a door closing coordinator to ensure the door with the astragal always closes last on the west door in the door set to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that latching hardware on smoke barrier doors must be maintained and in good working condition to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they are maintained and in good working condition as a part of the facility's Preventive Maintenance Program and document those	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Battery Operated Smoke Detector Maintenance Log" documentation for 2021 and 2022 with the Maintenance Director during record review from 8:35 a.m. to 11:15 a.m. on 09/01/22, resident room battery operated smoke detector preventive maintenance documentation for the most recent twelve month period did not include cleaning documentation. Based on interview at the time of record review, the Maintenance Director agreed monthly testing documentation for the detectors did not include detector cleaning. Based on observations with the Maintenance Director at 12:45 p.m. on 09/01/22, manufacturer's documentation affixed to the First Alert Model 0827 battery operated smoke detector installed on the ceiling in resident sleeping Room L-1 stated to clean the detector's sensor once per month. Based on interview at the	K 0300	**1) CORRECTIVE ACTIONS TAKEN**: a) The Maintenance Supervisor/designee cleaned the battery operated smoke detectors in all resident rooms to meet set standards. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) The Administrator inserviced the Maintenance Supervisor/designee on the requirement that battery operated smoke alarms must be maintained per manufacture's guidelines and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will clean the battery-operated smoke detectors once per month and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time of the observations, the Maintenance Director stated the facility has the same type of battery operated smoke detector installed in all resident sleeping rooms. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 3 of over 12 hazardous areas such as fuel-fired heater rooms, soiled linen rooms (exceeding 64 gallons) and Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the following was noted: a. the annular space surrounding a one inch in diameter water line which penetrated the back wall of the Mechanical Room near the center nurse's station was not firestopped. The room contained two natural gas fired water heaters. b. a three inch hole was noted in the ceiling next	K 0321	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee sealed the annular space surrounding a one inch in diameter water line which penetrated the back wall of the Mechanical Room near the center nurses station with a 1 hour fire rated material to meet set standards. b. The Maintenance Supervisor/designee sealed the 3 inch hole in the ceiling next to the sprinkler in the soiled utility room near the entrance door to Hope Hall with a 1 hour fire rated material to meet set standards. c. The Maintenance Supervisor/designee sealed the one inch in diameter open ended	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to 1 of 2 sprinklers in the soiled utility room near the entrance door to Hope Hall which exposed the attic above. c. a one inch in diameter open ended conduit penetrated the ceiling of the Laundry room behind the washing machines. Based on interview at the time of the observations, the Maintenance Director agreed the openings in the walls and ceiling of the aforementioned rooms did not separate these hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		conduit that penetrated the ceiling of the Laundry room behind the washing machine with a 1 hour fire rated material to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all hazardous areas for penetrations and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous areas must be maintained and free of penetrations to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous areas throughout the facility monthly for penetrations as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 7.8.2.1(8) requires rooftop terminations to be arranged with or provided with a hinged upblast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit inspection and cleaning that is listed for commercial cooking equipment. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood system contractor's "Job Service Report" inspection documentation dated 03/07/22 with the Maintenance Director during record review from 8:35 a.m. to 11:15 a.m. on 09/01/22, the range hood exhaust system fans needs hinge kits. The "Noticed Areas of Concerns/Deficiencies" section of the 03/07/22 report stated "need fan hinges" and the "Comments" section of the report stated "Both fans need hinge kits". Based on interview at the time of record review, the Maintenance Director stated he was not aware of any recent hinge kit installation and stated hinge kit installation documentation on or after 03/07/22 was not available for review at the time of the survey. This finding was reviewed with the Administrator and the Maintenance Director during the exit	K 0324	**1. CORRECTIVE ACTIONS TAKEN**: a. A Certified Contractor installed the fan hinge kits on the range hood exhaust systems to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one kitchen. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that the kitchen range hood exhaust system must be maintained in proper working condition to meet set standards. b. Maintenance Supervisor/designee will inspect the kitchen hood system monthly to ensure the kitchen hood exhaust system is properly maintained as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b)		inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls in 1 of 4 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room L-6 and L-7. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, an eight inch long by five inch high gash was noted in the corridor wall just above the floor between resident sleeping Room L-6 and L-7 which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the opening in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0362	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee repaired the hole in the corridor wall just above the floor between resident sleeping room L-6 and L-7 with a one hour fire rated material to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all other areas throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that all corridor walls throughout the facility must be maintained in good condition to meet set standards. b. Maintenance Supervisor/designee will inspect	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			all corridor walls throughout the facility monthly to ensure they remain in good condition as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 1 electrical junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of Room L-3. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the electrical junction box mounted in the attic above the attic access door in the restroom of resident sleeping Room L-3 was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0511	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee installed a cover on the electrical junction box mounted in the attic above the attic access door in the restroom of resident sleeping room L3 to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all electrical junction boxes throughout the facility to ensure they are maintained and in a safe operating condition and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical junction boxes must be maintained and in a safe operating condition to meet set standards. b. Maintenance Supervisor/designee will inspect all electric junction boxes throughout the facility monthly to ensure they are maintained and in	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		safe operating condition as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies	K 0761	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances		Supervisor/designee conducted the annual testing and inspections of required fire rated doors including the oxygen storage room and documented those inspection results on the Annual Door Inspections log to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire rated doors must be conducted and documented on the Annual Door Inspections log and maintained at the facility to meet set standards. b. The Maintenance Supervisor/designee will conduct the annual door inspections and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 8:35 a.m. to 11:15 a.m. on 09/01/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one oxygen storage room located inside the facility and agreed annual fire door inspection documentation for the corridor door to the room was not available for review. The Maintenance Director stated he had been working on fire door inspections for the facility but it was not available for review at the time of the survey. Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, a single leaf fire-rated corridor door to the oxygen storage and transfilling room near the center nurse's station was noted. The door was equipped with a 90 minute fire resistance		Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rating label affixed to the hinge side of the door. Six liquid containers and fourteen 'E' type oxygen cylinders were stored in the room. In addition, 90-minute fire resistance rating labels were affixed to the hinge sides of the corridor door sets in the Faith Hall and the Love Hall. A one-hour fire resistance rating label was affixed to the corridor door to the Mechanical Room by the center nurse's station which contained two natural gas fired water heaters. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors in the main building (Building 01).	K 0918	1. **CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee conducted the thirty six month period emergency generator test for four continuous hours and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that a thirty six month period emergency generator test for four continuous hours is required to meet set standards. b. The Maintenance	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review with the Maintenance Director from 8:35 a.m. to 11:15 a.m. on 09/01/22, thirty-six month period emergency generator testing documentation for four continuous hours for the natural gas fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one natural gas fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the facility has one natural gas fired emergency generator located inside the Maintenance Office near the south exit door for the facility. The manufacturer's nameplate rating for the generator could not be determined. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Supervisor/designee will ensure a thirty six month period emergency generator test for four continuous hours is conducted every three years and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 4 of 14 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section	K 0923	1. **CORRECTIVE ACTIONS TAKEN**: a. The Director of Nursing/designee secured the four E type oxygen cylinders in the	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room across from the entrance to the Main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, four of fourteen 'E' type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room across from the entrance to the Main Dining Room and were not properly secured from falling. Six liquid oxygen containers and fourteen 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the four oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling in the oxygen storage and transfilling room. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		oxygen storage/trans-filling room across from the entrance to the Main Dining Room to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The DON/designee checked all areas of the facility for improperly stored oxygen cylinders and containers and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the DON/designee and all other nursing staff on the requirement that oxygen cylinders and liquid oxygen containers must be restrained and in the proper storage areas to meet set standards. b. The Director of Nursing/designee will inspect all oxygen cylinders and liquid oxygen containers throughout the facility weekly to ensure they are restrained and properly stored as a part of the facility's Oxygen Policy and Procedures Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			c. The Administrator will monitor adherence to the Oxygen Policy & Procedures schedule and validate the Oxygen Policy & Procedures are in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	