STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155581	A. BUILDING -- B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

(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: 03/05/24 Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450 At this Emergency Preparedness survey, The Waters of Syracuse Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 66 certified beds. Sixty beds are dually certified for Medicare and Medicaid. Six beds are certified for Medicare only. At the time of the survey, the census was 39. Quality Review completed on 03/06/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/05/24 Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450	K 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anna Foster	HFA	03/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	At this Life Safety Code survey, The Waters of Syracuse Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, the 2010 edition of the National Fire Protection Association (NFPA) 99 Health Care Facilities Code and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has 66 certified beds. Sixty beds are dually certified for Medicare and Medicaid. Six beds are certified for Medicare only. At the time of the survey, the census was 39. All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance equipment, shed, and enclosed generator house. Quality Review completed on 03/06/24		executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. The facility is requesting paper compliance for all deficiencies in this plan of correction.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			

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	through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 8 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect 15 residents in the 200-hall. Findings include: Based on observations with the Environmental Supervisor on 03/05/24 at 11:33 a.m., the outer exit door #7 was equipped with panic hardware, but the door would not open on the first try. The Environmental Supervisor tried four times to open the door and was unable to open the door. The surveyor tried two times to open the door and with great force the door opened on the third try. Based on an interview at the time of observation, the Environmental Supervisor agreed it took excessive force to open the exit door. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0211	It is the intent of the facility to ensure to maintain exit discharges doors are free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1 to meet set standards. CORRECTIVE ACTIONS TAKEN: On 3/11/24 the Maintenance Supervisor/designee made repairs to the outer exit door #7 to meet set standards. The Administrator verified the work on 3/15/24. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were. MEASURES TO PREVENT REOCCURRENCE: On 3/21/24 the Administrator in-serviced the Maintenance Supervisor/designee and all other staff on the requirement to ensure to maintain exit discharge doors to meet set standards. Maintenance Supervisor/designee will inspect all exit discharge doors weekly to ensure they are continuously 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	03/21/2024

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			the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/21/24.	
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather			

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	travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 4 of 8 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice affects all residents in all resident halls. Findings include: Based on observation with the Environmental Supervisor on 03/05/24 between 11:00 a.m. to 12:15 p.m., there were four asphalt walkway exit discharges from all resident halls that went around the sides and rear of the building leading to the common way. The complete walkway was uneven, had holes, dips, bumps, a two inch drop from the door concrete pads, and had grass and tree roots growing through the cracks, Based on interview at the time of observation, the Environmental Supervisor agreed the walkway was in poor condition and did not provide an unobstructed level walking surface. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0271	It is the intent of the facility to ensure exit discharges are provided with an unobstructed level walking surface in accordance with NFPA 101 section 7.7 to meet set standards. CORRECTIVE ACTIONS TAKEN: On 3/21/24 the Maintenance Supervisor/designee repaired the complete walkway to meet set standards. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were. MEASURES TO PREVENT REOCCURRENCE: Maintenance Supervisor/designee will inspect all exit discharge and walkways to ensure they are readily accessible and free of holes, dips, bumps as a part of the facility's Monthly 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. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	03/21/2024

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			MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/21/24.	
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			

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	the door. 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 1 of 1 storage rooms on the 200-hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 15 residents in the 200-hall. Findings include: Based on observation during a tour of the facility with Environmental Supervisor on 03/05/24 at 10:58 p.m., room 204 was used as storage containing over 20 boxes of combustible supplies, was greater than 50 square, therefore making the rooms hazardous areas. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Environmental Supervisor agreed the room contained large amount of combustible storage, was larger than 50 square	K 0321	It is the intent of the facility to ensure storage rooms on the 200 hall with large amounts of combustible storage and greater than 50 square feet is protected as a hazardous area to meet set standards. CORRECTIVE ACTIONS TAKEN: On 3/15/24 the Maintenance Supervisor/designee removed the combustible storage items from Room 204 to meet set standards. The Administrator verified the work on 3/15/24. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were. On 3/15/24 the Maintenance Supervisor/designee inspected all	03/21/2024

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	feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		storage rooms for a self-closing or automatic closing device and found no other negative findings. MEASURES TO PREVENT REOCCURRENCE: On 3/15/24 the Administrator in-serviced the Maintenance Supervisor/designee/all staff on the requirement that all hazardous area doors must be protected with a self-closing device or be free of combustibles to meet set standards. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure there is a self-closing device or free of combustibles 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. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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			Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/21/24.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct			

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	supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 smoking policies and ensure cigarette butt were disposed in a non-combustible container with a self-closing lid. This deficient practice could affect staff around the employee entrance and 20 residents using the front exit. Findings include: Based on observations with the Environmental Supervisor and Maintenance Director on 03/05/24 between 9:00 a.m. and 12:30 p.m., the designated smoking was out by the shed on the side of the property. Smoking took place in non-smoking areas and cigarette butts were not properly disposed due to the following: a.) Upon arrival to the facility a staff member was smoking outside the employee entrance (a non-smoking area). b) On the front entrance porch (a non-smoking area) there was a glass jar containing disposed cigarette butts. c) In the staff smoking area the smoker's pole top half was missing exposing the disposed cigarette butts. d) Inside the facility by the employee entrance there were three cigarette butts in a plastic can with a plastic bag. Based on record review a staff smoking policy was not available for review.	K 0741	It is the intent of the facility to enforce smoking procedures and ensure cigarette butts are disposed in a non-combustible container with a self-closing lid to meet set standards. CORRECTIVE ACTIONS TAKEN: On 3/6/24 the Administrator/DON/Maintenance Supervisor/designee identified the facilities designated smoking area and purchased approved smoking containers for the staff smoking area to meet set standards. The Administrator verified the work on 3/15/24. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were. MEASURES TO PREVENT REOCCURRENCE: On 3/21/24 the Administrator in-serviced all staff on the designated location of the smoking area and how to properly dispose of the cigarette butts to	03/21/2024

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	Based on interview at the time of observation and records review, the Maintenance Director stated smoking is allowed in the staff smoking area and confirmed there was smoking in non-smoking areas and cigarette butts were not properly disposed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		meet set standards. Maintenance Supervisor/designee will ensure the designated smoking area continues to be the properly identified smoking area 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. The Administrator will monitor adherence to the smoking procedure and validate the Preventative Maintenance documentation is in place. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/21/24.	

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