

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

PRINTED: 03/28/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155581		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/27/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/05/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 03/27/24</p> <p>Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450</p> <p>At this PSR survey, The Waters of Syracuse Skilled Nursing Facility was found 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.</p> <p>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.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of</p>			{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155581	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/27/2024
NAME OF PROVIDER OR SUPPLIER WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	Continued From page 1 maintenance equipment, shed, and enclosed generator house. Quality Review completed on 03/27/24	{K 000}			