STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155211	A. BUILDING -- B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF LEBANON, THE	1585 PERRY WORTH RD LEBANON, IN 46052

(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: 08/14/23 Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470 At this Emergency Preparedness survey, The Waters of Lebanon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 37. Quality Review completed on 08/18/23	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: 08/14/23 Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470 At this Life Safety Code survey, The Waters of Lebanon was found not in compliance with	K 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Peter	Administrator	08/28/2023

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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	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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has no residents on the 300 hall, it is separated by a code access door and is therefore used primarily for storage. The facility has also leased space to Renpro, a dialysis company that has a training facility located within some of the space on the 300 hall. The facility has a capacity of 64 and had a census of 37 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings: one housing an emergency generator and one detached sprinkler system fire pump building which were each not sprinklered. Quality Review completed on 08/18/23		**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, 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 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. Facility respectfully request a desk review on K211.** The facility requests a desk review.	
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			

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	emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 3 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations with the facility Administrator and the Maintenance Director during a tour of the facility on 08/14/23 at 12:01 p.m., the hall outside resident room #216 had a contact isolation cabinet sitting immediately outside the resident room doors. This cabinet was approximately 18 inches by 18 inches by 24 inches high, was not on wheels, and contained personal protective equipment. Based on interview with the Maintenance Director, the cabinet was stored in the corridor to allow staff quick access to it before entering the resident rooms. The storage of the contact isolation cabinet in the corridor was	K 0211	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, 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 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. K211 – It is the intent of the facility to ensure to maintain the means of egress free from obstructions in corridors within the facility to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 8/14/2023 the Maintenance Supervisor/designee removed the contact isolation cabinet sitting in the hall outside resident room #216 to meet set standards. The Administrator verified the work on 8/14/2023. 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. On 8/14/2023 the Maintenance	08/30/2023

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	verified by the Administrator and the Maintenance Director at the time of the observation. During the exit conference with the facility Administrator and the Maintenance Director on 08/14/23 at 1:29 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		Supervisor/designee inspected all corridors and exit doors for obstructions and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On 8/29/2023 the Administrator in-serviced the Maintenance Supervisor/designee and other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions 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	

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			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 8/30/2023.	