PRINTED: 02/13/2024 FORM APPROVED

| CENTERS FOR               | R MEDICARE & MEDIC   | CAID SERVICES   |  | OMB NO. 0938                                     |  |  |                            |
|---------------------------|--|---|--|--|--|--|----------------------------|
|                           | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233   | A. BU  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY  COMPLETED  01/24/2024    |                            |
|                           | PROVIDER OR SUPPLIE  |   | STREET ADDRESS, CITY, STATE, ZIP COD  958 E HWY 46  BATESVILLE, IN 47006 |  |  |  |                            |
| (X4) ID PREFIX TAG F 0000 | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | ATE  | (X5)<br>COMPLETION<br>DATE |
| E 0000<br>Bldg            | conducted by the In accordance with 42 Survey Date: 01/2 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Waters of Batesvill with Emergency Property Medicare and Medicare and Medicare and Suppliers, 42 Control The facility has 86 the survey, the central MET as evidenced  482.15(e), 483.73 Hospital CAH and §482.15(e) Condicing Emergency are The hospital must standby power system emergency plans this section and in | 4/24  000138 155233 0266500  Preparedness survey, The le was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.73.  certified beds. At the time of sus was 55.  mpleted on 01/29/24  42 CFR, Subpart 483.73 is NOT by:  8(e), 485.625(e) d LTC Emergency Power ition for Participation: nd standby power systems. It implement emergency and vistems based on the set forth in paragraph (a) of in the policies and set forth in paragraphs (b)(1) | E 00   | 000  | DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specicorrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes and the plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes a written allegation constitutes a wr | nn<br>this<br>r<br>he<br>fic<br>red<br>ice |                            |
|                           | §483.73(e), §485   |   |  |  |  |  |                            |

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

(e) Emergency and standby power systems.

TITLE (X6) DATE

Jalena Ball Administrator 02/09/2024

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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SU |  | X1) PROVIDER/SUPPLIER/CLIA                               | (X2) MULTIPLE CONSTRUCTION |             |  | (X3) DATE SURVEY |            |  |
|---|--|--|----------------------------|-------------|--|------------------|------------|--|
| AND PLAN                                  | OF CORRECTION  | IDENTIFICATION NUMBER                                    | A. BU                      | A. BUILDING |  |                  | COMPLETED  |  |
|   |  | 155233   | B. W                       | ING         |  | 01/24/           | /2024      |  |
| NAME OF T                                 | DROLUDED OF CURRY TO   |  | _                          | STREET A    | ADDRESS, CITY, STATE, ZIP COD  |                  |            |  |
| NAME OF I                                 | PROVIDER OR SUPPLIER   | (  |                            | 958 E H     | IWY 46   |                  |            |  |
| WATERS                                    | OF BATESVILLE,   | THE  |                            | BATES       | VILLE, IN 47006  |                  |            |  |
| (X4) ID                                   |  |  |                            | ID          | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |  |
| PREFIX<br>TAG                             | `  | ICY MUST BE PRECEDED BY FULL                             |                            | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE               | COMPLETION |  |
| TAG                                       | REGULATORY OR LSC IDENTIFYING INFORMATION  The [LTC facility and the CAH] must |  |                            | TAG         | 2200000  |                  | DATE       |  |
|   |  | ency and standby power                                   |                            |             |  |                  |            |  |
|   |  | the emergency plan set                                   |                            |             |  |                  |            |  |
|   | _  | (a) of this section.                                     |                            |             |  |                  |            |  |
|   |  |  |                            |             |  |                  |            |  |
|   | - , , , , -  | 83.73(e)(1), §485.625(e)(1)                              |                            |             |  |                  |            |  |
|   |  | ator location. The                                       |                            |             |  |                  |            |  |
|   |  | e located in accordance with                             |                            |             |  |                  |            |  |
|   | -  | rements found in the Health<br>de (NFPA 99 and Tentative |                            |             |  |                  |            |  |
|   |  | nts TIA 12-2, TIA 12-3, TIA                              |                            |             |  |                  |            |  |
|   |  | nd TIA 12-6), Life Safety                                |                            |             |  |                  |            |  |
|   |  | and Tentative Interim                                    |                            |             |  |                  |            |  |
|   | Amendments TIA   | 12-1, TIA 12-2, TIA 12-3,                                |                            |             |  |                  |            |  |
|   |  | d NFPA 110, when a new                                   |                            |             |  |                  |            |  |
|   |  | r when an existing                                       |                            |             |  |                  |            |  |
|   | structure or buildir   | ng is renovated.   |                            |             |  |                  |            |  |
|   | 482 15(e)(2) 848:  | 3.73(e)(2), §485.625(e)(2)                               |                            |             |  |                  |            |  |
|   | , , , , =  | rator inspection and testing.                            |                            |             |  |                  |            |  |
|   |  | H and LTC facility] must                                 |                            |             |  |                  |            |  |
|   | implement the em   | ergency power system                                     |                            |             |  |                  |            |  |
|   | inspection, testing  | յ, and [maintenance]                                     |                            |             |  |                  |            |  |
|   |  | nd in the Health Care                                    |                            |             |  |                  |            |  |
|   | 1  | FPA 110, and Life Safety                                 |                            |             |  |                  |            |  |
|   | Code.  |  |                            |             |  |                  |            |  |
|   | 482 15(e)(3) 848°  | 3.73(e)(3), §485.625(e)(3)                               |                            |             |  |                  |            |  |
|   |  | rator fuel. [Hospitals, CAHs                             |                            |             |  |                  |            |  |
|   |  | that maintain an onsite fuel                             |                            |             |  |                  |            |  |
|   | _  | mergency generators must                                 |                            |             |  |                  |            |  |
|   | •  | w it will keep emergency                                 |                            |             |  |                  |            |  |
|   |  | perational during the                                    |                            |             |  |                  |            |  |
|   | emergency, unles   | s it evacuates.  |                            |             |  |                  |            |  |
|   | *[For hospitals at   | §482.15(h), LTC at                                       |                            |             |  |                  |            |  |
|   |  | CAHs §485.625(g):]                                       |                            |             |  |                  |            |  |
|   | (0)  | corporated by reference in                               |                            |             |  |                  |            |  |
|   | this section are ap  | proved for incorporation by                              |                            |             |  |                  |            |  |
|   | reference by the D   | Director of the Office of the                            |                            |             |  |                  |            |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233 |                          | A. B   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |  |   | (X3) DATE SURVEY COMPLETED 01/24/2024 |    |                            |
|---|--------------------------|--|--|--|---|---------------------------------------|----|----------------------------|
|   |                          | ROVIDER OR SUPPLIER<br>OF BATESVILLE,  |  | STREET ADDRESS, CITY, STATE, ZIP COD  958 E HWY 46  BATESVILLE, IN 47006 |   |                                       |    |                            |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  |  | ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) |                                       | TE | (X5)<br>COMPLETION<br>DATE |
|   |                          | Federal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resoult Boulevard, Baltime Archives and Rece (NARA). For information this material at NA go to:  http://www.archive_of_federal_regulated in the Fannounce the charan (1) National Fire Fannounce the charan (1) National Fire Fannounce, MA 021691.617.770.3000.  (i) NFPA 99, Health 2012 edition, issued (iii) TlA 12-3 to NF 2012.  (iv) TIA 12-4 to NF 2013.  (v) TIA 12-5 to NF 2013.  (vi) TIA 12-6 to NF 2014.  (vii) NFPA 101, Little dition, issued Au (viii) TIA 12-1 to NF 2014.  (viii) TIA 12-1 to NF 2014. | n accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It copy at the CMS Ince Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to larges. Protection Association, 1 k, 9, www.nfpa.org,  th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9,  FPA 99, issued March 7,  FPA 99, issued August 1,  FPA 99, issued March 3,  fe Safety Code, 2012 |  |   |                                       |    |                            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233 |  | A. BU  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  |   | (X3) DATE SURVEY  COMPLETED  01/24/2024    |            |
|--|--|--|--|--|---|--|------------|
|  | PROVIDER OR SUPPLIER   |  |  | 958 E H  | ADDRESS, CITY, STATE, ZIP COD<br>HWY 46<br>SVILLE, IN 47006   |  |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE   |  | ID   | PROVIDER'S PLAN OF CORRECTION   |  | (X5)       |
| PREFIX   | ,  | ICY MUST BE PRECEDED BY FULL   |  | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR |   | .TE  | COMPLETION |
| TAG  | REGULATORY OF  | R LSC IDENTIFYING INFORMATION  |  | TAG  | DEFICIENCY)   |  | DATE       |
|  | 22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 6 2009 Based on record rev interview; the facili  | standard for Emergency and systems, 2010 edition, chapter 7, issued August 6, view, observation and ty failed to implement the   | E 0  | 041  | <b>E041</b> – It is the intent of the factor to ensure to implement the   | cility                                     | 02/13/2024 |
|  | maintenance requir<br>Care Facilities Cod<br>Code in accordance  | ystem inspection, testing and ements found in the Health e, NFPA 110, and Life Safety with 42 CFR 483.73(e)(2). ice could affect all residents,  |  |  | emergency power system inspection, testing and maintenance requirements for in the Health Care Facilities C NFPA 110 and Life Safety Co accordance with 42 CFR 483.  (2) to meet set standards.  1 CORRECTIVE ACTIONS TAKEN:  | ode,<br>de in<br>73(e)                     |            |
|  | with the Maintenan review from 9:45 a monthly load testin facility's diesel fuel not consistently me nameplate kW ratir testing documentati 12/07/23 indicated test. Monthly load 01/04/24 indicated test. Based on review. Generator-Monthly dated 09/07/23 with thirty-six-month petesting documentati for the diesel fired of | Test Log" documentation ce Director during record .m. to 12:15 p.m. on 01/24/24, g documentation for the fired emergency generator did et or exceed 30% of the ag of the EPS. Monthly load ion for 11/02/23 and for 19% load was achieved for the testing documentation for 25% load was achieved for the ew of "Emergency". Test Log" documentation in the Maintenance Director, riod emergency generator ion for four continuous hours emergency generator was |  |  | a On02/08/2024 a licensed generator contractor conducted the three-year four test on the emergency general and documented the results in facilities Life Safety Binder to meet set standards. The Administrator verified the work02/08/2024 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTION A MI residents and all staff and visitors have the potential be affected but none were.  3 MEASURES TO PREVERECCURRENCE:  a OnJan. 24, 2024 the Administrator in serviced the | -hour<br>tor<br>the<br>C<br>ED:<br>f<br>to |            |
|  | for the duration of the time of record r Director stated he c  | chility but was run at 32% load the test. Based on interview at eview, the Maintenance conducted the four hour load was not performed by an  |  |  | Maintenance Supervisor/design on the requirement that a three-year four-hour test on the emergency generator must be conducted and documented in  | ie<br>e                                    |            |

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|                          | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155233   | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING      |  | DATE SURVEY COMPLETED 01/24/2024 |
|--------------------------|--|--|--|----------------------------------|
|                          | PROVIDER OR SUPPLIER S OF BATESVILLE, THE  | STREET ADDRESS,<br>958 E HWY 46<br>BATESVILLE, I |  |                                  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  outside contractor and agreed the testing  documentation did not state the remaining hour of | PREFIX CROSS TAG facilitie                       | PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)  es Life Safety Binder to set standards. | (X5) COMPLETION DATE             |
|                          | the four hour load test was not conducted at not less than 75 percent of the nameplate kW rating of the EPS. Based on observations with the Maintenance Director during a tour of the facility                       | b T<br>Super<br>three-y                          | The Maintenance<br>visor/designee will ensure a<br>year four-hour generator tes<br>ducted and documented in                                      |                                  |
|                          | from 12:45 p.m. to 2:50 p.m. on 01/24/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. The manufacturer's nameplate rating for          | standa<br>c T<br>monito                          | The Administrator will<br>or adherence to the  |                                  |
|                          | the generator indicated the generator was rated at 45 kW.  These findings were reviewed with the Administrator and the Maintenance Director  | Manua<br>docum<br>4                              | gency Preparedness Policy al and validate the nentation is in place. MONITORING RECTIVE ACTION:  |                                  |
|                          | during the exit conference.  3.1-19(b)   | a A<br>the fou<br>comple                         | At least every three years<br>ur-hour load test will be<br>eted to ensure compliance,<br>dministrator and  |                                  |
|                          |  | will rev<br>Prepai<br>make o                     | enance Supervisor/designee<br>view the Emergency<br>redness Policy Manual and<br>changes as necessary to   |                                  |
|                          |  | review<br>approp<br>preser                       | set standards. Those  /s will be documented as  priate. The Administrator will  nt the training results at the  y Assurance/ Performance         | ı                                |
|                          |  | Improv<br>Result<br>will be                      | vement (QA/PI) meeting. ts and system components reviewed by the QA/PI nittee with subsequent plans  |                                  |
|                          |  | of corr<br>implen<br>necess                      | rection developed and mented as deemed sary to ensure compliance ntained.  |                                  |
|                          |  | consti<br>allega                                 | olan of correction<br>itutes our credible<br>ition of compliance with  |                                  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233 |   | (X2) MULTIPL<br>A. BUILDING<br>B. WING   | E CONSTRUCTION  G <u></u> | (X3) DATE SURVEY  COMPLETED  01/24/2024  |   |
|--|---|--|---------------------------|--|---|
| WATERS   | ROVIDER OR SUPPLIER   |  | 958                       | EET ADDRESS, CITY, STATE, ZIP COD<br>E HWY 46<br>FESVILLE, IN 47006  |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG       | DEFICIENCY)  | D BE COMPLETION DATE  |
|  |   |  |                           | Our date of compliance is02/13/2024  | s<br>·  |
| K 0000   |   |  |                           |  |   |
| Bldg. 01   | Licensure Survey w Department of Heal 483.90(a).  Survey Date: 01/24  Facility Number: 0 Provider Number: 1002  At this Life Safety C Batesville was foun Requirements for Pa Medicare/Medicaid Life Safety from Fit National Fire Protec Life Safety Code (L Health Care Occupa  This one story facilit Type V (111) constr The facility has a fit detection in the corr corridors, and has b detectors in all resid facility has a capaci 55 at the time of this  All areas where resi were sprinkled and | 200138 206500 Code survey, The Waters of d not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Ty was determined to be of ruction and fully sprinkled. The alarm system with smoke ridors, spaces open to the attery operated smoke lent sleeping rooms. The ty of 86 and had a census of s visit.  The dents have customary access all areas providing facility cled except the two story | K 0000                    | DISCLAIMER STATEMEN Preparation and/or execut of this plan of correction general, or this corrective action, does not constitut admission or agreement facility of the facts allege conclusions set forth in t statement of deficiencies plan of correction and sp corrective actions are pre and/or executed in comp with state and federal law This plan of correction constitutes a written alleg of substantial compliance Federal Medicare and Medicaid requirements. | ution in e tte an by this ed or this s. The pecific epared liance vs. |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233 |  | (X2) MULTIPLE A. BUILDING B. WING   | construction 01     | (X3) DATE SURVEY  COMPLETED  01/24/2024  |   |
|--|--|---|---------------------|--|---|
|  | PROVIDER OR SUPPLIER   |   | 958 E               | T ADDRESS, CITY, STATE, ZIP COD<br>E HWY 46<br>ESVILLE, IN 47006   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   | (X5) COMPLETION DATE                                      |
| K 0211<br>SS=E<br>Bldg. 01   | Quality Review con<br>NFPA 101<br>Means of Egress -<br>Means of Egress -<br>Aisles, passagewa  | General<br>General  |                     |  |   |
|  | discharges, exit lo in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 2 of continuously maintator impediments to fire or other emerge   | cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility 8 means of egress were uned free of all obstructions full instant use in the case of ney. This deficient practice of residents, staff and visitors if   | K 0211              | K211– It is the intent of the fato ensure the means of egres continuously maintained free obstructions or impediments instant use in the case of fire other emergency to meet set standards.  1 CORRECTIVE ACTION TAKEN:   | ss are of all to full or                                  |
|  | Based on observation Director during the facility from 9:25 and plastic three drawer supplies was stored resident sleeping roon observations with Maintenance Direct from 12:45 p.m. to a three drawer chest of supplies were still stresident sleeping root the four chest of drawers of drawers. | ons with the Maintenance initial walk through of the m. to 9:40 a.m. on 01/24/24, a chest of drawers for isolation in the corridor outside oms 33, 39, 47 and 51. Based the Administrator and the or during a tour of the facility 2:50 p.m. on 01/24/24, the plastic of drawers for isolation tored in the corridor outside oms 33, 39, 47 and 51. Each of overs were not affixed to the and were not wheeled. Each of a projected 18 inches into the idors. Based on interview at |                     | a On02/12/2024 the Maintenance Supervisor/designee replaced chest of drawers with new che drawers with wheels on them the corridor outside resident sleeping rooms 33, 39, 47 and to meet set standards. The Administrator verified the wor02/12/2024  2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all state and visitors have the potential be affected but none were. | d the nest of n from nd 51  rk on  FED:  off dal to On ne |

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|                          | NT OF DEFICIENCIES OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233  | (X2) MULTIPLE C A. BUILDING B. WING  | O1   | (X3) DATE SURVEY COMPLETED 01/24/2024   |  |  |  |
|--------------------------|--|--|--|--|---|--|--|--|
|                          | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>958 E HWY 46<br>BATESVILLE, IN 47006 |  |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)  | N (X5)  BE COMPLETION  DATE   |  |  |  |
| 1AG                      | the time of the obse<br>Director agreed the<br>egress was not cont<br>obstructions or imp<br>the case of fire or o | ervations, the Maintenance aforementioned means of inually maintained free of all ediments to full instant use in ther emergency.  The reviewed with the he Maintenance Director | TAG  | inspected all corridors for obstructions and found no congative findings.  3 MEASURES TO PRESE REOCCURRENCE:  a OnJan. 24, 2024 the Administrates serviced the Maintenance Supervisor/designee and all staff on the requirement to come means of egress are continuated free of all obstruincluding chest of drawers the set standards.  b Maintenance Supervisor/designee will install corridors weekly to ensurate continuously maintained of all obstructions as a partifacility's Preventive Maintenance of all obstructions as a partifacility's Preventive Maintenance will be addressed and resolute immediately. The Maintenance will be addressed and resolute immediately. The Maintenance 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 be presented by the Mainte Supervisor/designee to the Administrator monthly and the Administrator monthly an | other  VENT  tor in  I other ensure uously uctions o meet  spect re they diffree of the nance se oriate. di, they wed ince view |  |  |  |

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|                            | OF CORRECTION  | IDENTIFICATION NUMBER  155233  | A. BUILDING <u>01</u> B. WING  |   | COMPLETED 01/24/2024 |  |  |
|----------------------------|--|--|--|---|----------------------|--|--|
|                            | ROVIDER OR SUPPLIER OF BATESVILLE,   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>958 E HWY 46<br>BATESVILLE, IN 47006 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | (X5) COMPLETION DATE |  |  |
| K 0918<br>SS=F<br>Bldg. 01 | Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the si switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mon Scheduled test und a complete simula | other alternate power ated equipment is capable the within 10 seconds. If the in is not met during the the deess shall be provided to inis capability for the life the branches. Maintenance generator and transfer remed in accordance with the inspected weekly, and 30 minutes 12 times a sintervals, and exercised inthe for 4 continuous hours. der load conditions include |  | Administrator will present the inspection results at the monti Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is02/13/2024 | by n as              |  |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                 |     |                     | (X3) DATE SURVEY COMPLETED 01/24/2024   |                     |                            |
|--|--|--|-----|---------------------|---|---------------------|----------------------------|
|  | PROVIDER OR SUPPLIER   |  |     | 958 E H             | ADDRESS, CITY, STATE, ZIP COD<br>HWY 46<br>VILLE, IN 47006  |                     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE                  | (X5)<br>COMPLETION<br>DATE |
|  | personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requipant of maintenance are and readily availal and circuits are manufacturer for maintenance are and separate from Minimizing the postemergency power consideration for reference of 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record revinterview; the facility period emergency generated 99 and NFPA 110. Code, 2012 Edition 1 and Type 2 essent sources (EPSS) shall Class X, Level 1 genergency generates (EPSS) shall class X, Level 1 genergency states Level 1 once within every 3 states Level 1 EPSS for the duration of in 4.2). Section 8.4.9. states than to terminate the test section 8.4.9.5 states test shall be specified 8.4.9.5.3. Section 8.4.9 | (NFPA 99), NFPA 110,   | K 0 | 918                 | K918 – It is the intent of the facility to ensure to document 36-month period emergency generator testing for the emergency generators in accordance with NFPA 99 & NFPA 110 to meet set standar 1 CORRECTIVE ACTIONS TAKEN:  a On02/08/2024 a licensed generator contractor conducted the three-year fourtest on the emergency genera and documented the results in facilities Life Safety Binder to meet set standards. The Administrator verified the work 02/08/2024 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff and visitors have the potential be affected but none were. | -hour<br>tor<br>the | 02/13/2024                 |

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| STATEMENT OF DEFICIENCIES |   | X1) PROVIDER/SUPPLIER/CLIA          | (X2) MULTIPLE CONSTRUCTION |          | ONSTRUCTION  | (X3) DATE SURVEY |            |
|---------------------------|---|-------------------------------------|----------------------------|----------|--|------------------|------------|
| AND PLAN                  | OF CORRECTION                                     | IDENTIFICATION NUMBER               | A. BU                      | JILDING  | 01   | COMPL            | ETED       |
|                           |   | 155233                              | B. WI                      | ING      |  | 01/24/           | 2024       |
|                           |   |                                     |                            | STREET / | ADDRESS, CITY, STATE, ZIP COD  |                  |            |
| NAME OF P                 | PROVIDER OR SUPPLIEF                              | 8                                   |                            | 958 E H  |  |                  |            |
| \\/\\TEDS                 | COE BATESVILLE                                    | THE                                 |                            |          | VILLE, IN 47006  |                  |            |
| VVATERS                   | OF BATESVILLE,                                    | 1111                                |                            | DATES    | VILLE, IN 47 000   |                  |            |
| (X4) ID                   | SUMMARY   | STATEMENT OF DEFICIENCIE            |                            | ID       | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX                    | (EACH DEFICIEN                                    | CY MUST BE PRECEDED BY FULL         |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG                       | REGULATORY OF                                     | R LSC IDENTIFYING INFORMATION       |                            | TAG      | DEFICIENCY)  |                  | DATE       |
|                           |   | he minimum loading required         |                            |          | 3 MEASURES TO PREVE  | NT               |            |
|                           |   | emaining hour shall be at not       |                            |          | REOCCURRENCE:  |                  |            |
|                           | -   | of the nameplate kW rating of       |                            |          | a The Administrator in   |                  |            |
|                           | the EPS. This deficient practice could affect all |                                     |                            |          | serviced the Maintenance   |                  |            |
|                           | residents, staff and visitors.                    |                                     |                            |          | Supervisor/designee on the   |                  |            |
|                           |   |                                     |                            |          | requirement that a three-year  |                  |            |
|                           | Findings include:                                 |                                     |                            |          | four-hour test on the emergen  | су               |            |
|                           |   |                                     |                            |          | generator must be conducted  | and              |            |
|                           | Based on review of                                |                                     |                            |          | documented in the facilities Lit                                       | fe               |            |
|                           | Generator-Monthly Test Log" documentation         |                                     |                            |          | Safety Binder to meet set  |                  |            |
|                           |   | ce Director during record           |                            |          | standards.   |                  |            |
|                           | review from 9:45 a.m. to 12:15 p.m. on 01/24/24,  |                                     |                            |          | b The Maintenance  |                  |            |
|                           | monthly load testing                              | g documentation for the             |                            |          | Supervisor/designee will ensu  | re a             |            |
|                           | facility's diesel fuel                            | fired emergency generator did       |                            |          | three-year four-hour test of the                                       | 9                |            |
|                           | not consistently me                               | et or exceed 30% of the             |                            |          | emergency generator test is  |                  |            |
|                           | nameplate kW ratin                                | g of the EPS. Monthly load          |                            |          | conducted every three years a  | and              |            |
|                           | testing documentati                               | on for 11/02/23 and for             |                            |          | documented in the life safety  |                  |            |
|                           | 12/07/23 indicated                                | 19% load was achieved for the       |                            |          | binder as a part of the facility's                                     | 3                |            |
|                           | test. Monthly load                                | testing documentation for           |                            |          | Preventive Maintenance Prog  | ram              |            |
|                           | 01/04/24 indicated :                              | 25% load was achieved for the       |                            |          | and document those inspectio   | n                |            |
|                           | test. Based on revie                              | ew of "Emergency                    |                            |          | results as appropriate. If any   |                  |            |
|                           | Generator-Monthly                                 | Test Log" documentation             |                            |          | issues are discovered, they wi   | ll be            |            |
|                           | dated 09/07/23 with                               | the Maintenance Director,           |                            |          | addressed and resolved   |                  |            |
|                           | thirty-six-month pe                               | riod emergency generator            |                            |          | immediately. The Maintenand  | e                |            |
|                           | testing documentati                               | on for four continuous hours        |                            |          | Supervisor/designee will revie   | W                |            |
|                           |   | emergency generator was             |                            |          | with the Administrator the   |                  |            |
|                           | -   | cility but was run at 32% load      |                            |          | inspection results.  |                  |            |
|                           | for the duration of t                             | he test. Based on interview at      |                            |          | c The Administrator will   |                  |            |
|                           | the time of record re                             | eview, the Maintenance              |                            |          | monitor adherence to the   |                  |            |
|                           |   | onducted the four hour load         |                            |          | Preventative Maintenance   |                  |            |
|                           |   | was not performed by an             |                            |          | schedule and validate the  |                  |            |
|                           |   | nd agreed the testing               |                            |          | Preventative Maintenance   |                  |            |
|                           |   | not state the remaining hour of     |                            |          | documentation is in place.   |                  |            |
|                           |   | est was not conducted at not        |                            |          | 4 MONITORING   |                  |            |
|                           | _   | of the nameplate kW rating of       |                            |          | CORRECTIVE ACTION:   |                  |            |
|                           |   | observations with the               |                            |          | a The inspection results w   |                  |            |
|                           |   | for during a tour of the facility   |                            |          | be presented by the Maintena   | nce              |            |
|                           | _   | 2:50 p.m. on 01/24/24, the facility |                            |          | Supervisor/designee to the   |                  |            |
|                           |   | emergency generator located         |                            |          | Administrator monthly and the  |                  |            |
|                           | outside the building on the northeast side of the |                                     |                            |          | Administrator will present the   |                  |            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CO. AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING |                               | Onstruction<br>01   | (X3) DATE SURVEY COMPLETED 01/24/2024 |   |                           |
|--|-------------------------------|---|---------------------------------------|---|---------------------------|
| NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE   |                               |   | 958 E I                               | ADDRESS, CITY, STATE, ZIP COD<br>HWY 46<br>SVILLE, IN 47006   |                           |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE<br>REGULATORY O | STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION                                       | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | DATE                      |
|  | the generator indic<br>45 kW. | nufacturer's nameplate rating for sated the generator was rated at a re reviewed with the the Maintenance Director ference. |                                       | inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is02/13/2024 | ce<br>g.<br>by<br>n<br>as |

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