STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		(X3) DATE SURVEY COMPLETED	
		155556	B. WING		04/15/2025
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg	conducted by the In accordance with 42  Survey Date: 04/15  Facility Number: 06 Provider Number: 1  AIM Number: 1002  At this Emergency Waters of Tipton SI found not in compli Preparedness Requi Medicaid Participat CFR 483.73.  The facility has a cacensus of 88 at the to Quality Review control The requirement at MET as evidenced in the second	200505 55556 66350  Preparedness survey, The cilled Nursing Facility was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42  Apacity of 150 and had a time of this survey.  Impleted on 04/21/25  42 CFR Subpart 483.73 is NOT	E 0000	Preparation and or execution this plan of correction in generor this corrective action, does constitute an admission or agreement by this facility of the facts alleged or conclusions of forth in this statement of deficiencies. The plan of correction and specific correct actions are prepared and/or executed in compliance with seand federal laws. This plan of correction constitutes a writter allegation of substantial compliance with Federal Mediand Medicaid requirements.	ral, e not  e et tive state f
SS=F Bldg	Based on record reversal failed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based	rements  riew and interview, the facility ercises to test the emergency er year, including drills using the emergency C facility must do the  annual full-scale exercise that	E 0039	It is the intent of the facility to ensure to conduct exercises to test the emergency plan at leastwice per year, including unannounced staff drills using emergency procedures to measet standards.  1. On 05-09-2025 the Administrator and the	the
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

(X6) DATE

Susan Waymire Administrator 05/07/2025

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/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155556	B. W	ING		04/15/	/2025
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	3			IRGROUNDS RD		
WATERS	S OF TIPTON SKIL	LED NURSING FACILITY, THE			N, IN 46072		
	T		ı		, 		ave.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	facility-based funct	an annual individual,			DON/Maintenance	ad a	
	I				Supervisor/designee conducte	ed a	
		ty experiences an actual natural			full scale exercise that was	-l l	
	or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt				community based or an individ		
					facility-based functional exerc		
	from engaging its next required full-scale community-based or individual, facility-based				and documented the informat		
	· ·				on the after-action report and		
	the onset of the acti	l exercise for 1 year following			the Life Safety Binder to meet	set	
					standards.		
	1 1	itional exercise that may			2. All residents and all staff		
		imited to the following:			visitors have the potential to b	e	
	a. A second full-scale exercise that is				affected but none were.		
	functional exercise	or an individual, facility-based			3. On 04-29-2025 the	2011	
					Administrator in serviced the I		
	b. A mock disaster				Maintenance Supervisor/design	-	
	_	ise or workshop that is led by a			on the requirement to conduc	Į.	
		ides a group discussion, using			annual exercises to include a		
		y-relevant emergency scenario,			community or facility based		
		n statements, directed			exercise and document on the		
		red questions designed to			after-action report and in the l	_ife	
	challenge an emerg				Safety Binder to meet set		
		TC facility's response to and			standards.		
		ation of all drills, tabletop			![endif]>DON/Maintenance		
	· ·	rgency events, and revise the			Supervisor/designee will work		
		gency plan, as needed in			the Administrator to ensure ar		
		CFR 483.73(d)(2). This			exercise to include community	/	
	deficient practice c	ould affect all occupants.			based and record on the		
	Findings 1 1 1				after-action report to meet set		
	Findings include:				standards. If any issues are		
	Donal or (	SHE management Duranger de			discovered, they will be		
		"Emergency Preparedness			addressed and resolved		
		cumentation dated 12/05/24			immediately.		
		ator and the Maintenance			/p>	.:11	
	_	.m. on 04/15/25, documentation			4. a.The inspection results w		
	for a full-scale exercise that is community-based or				be presented by the Maintena	ınce	
	an individual, facility-based functional exercise				Supervisor/designee to the		
	within the most recent two year period was not				Administrator and the		
		v. The facility also did not			Administrator will present the		
		al natural or man-made			inspection results at the mont	-	
	emergency that req	uired activation of the	1		Quality Assurance/Performan	ce	I

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 04/15/2025	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE		300 FAI	ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	period. Based on in 04/15/25, the Admir preparedness testing available for review.  These findings were	he Maintenance Director			Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	py 1	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 04/15  Facility Number: 0 Provider Number: 1 AIM Number: 1002  At this Life Safety 0 Tipton Skilled Nurs compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa  This two story facil Type V (111) consts sprinklered except f floor which consiste	00505 55556	K 00	000	Preparation and or execution of this plan of correction in gener or this corrective action, does 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 corrections are prepared and/or executed in compliance with stand federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicand Medicaid requirements.	al, not e et ve ve tate	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155556	B. WI	NG		04/15/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			IRGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON, IN 46072			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on in the corridor and in all					
	•	orridor. The facility has					
		oke detectors in all resident					
		te facility has a capacity of 150					
	and had a census of	88 at the time of this survey.					
		idents have customary access					
	_	d all areas providing facility					
	•	klered except for one detached					
	storage barn which	was not sprinklered.					
	Quality Review cor	mpleted on 04/21/25					
K 0211	NFPA 101						
SS=E	Means of Egress	- General					
Bldg. 01	Wicaria of Egresa	Concrai					
2.49.0.	Based on observation	on and interview, the facility	K 0	211	It is the intent of the facility to		05/09/2025
		f 4 means of egress on the	1 1 0.	211	ensure to provide means of		03/07/2023
		ontinuously maintained free of			egresses that are continuously	<b>/</b>	
		mpediments to full instant use			maintained free of obstruction		
		r other emergency. This			full use in case of emergency	to	
	deficient practice co	ould affect over 10 residents,			meet set standards.		
	staff and visitors if	needing to exit the facility from			1. On 04-24-2025 the		
	the second floor.				Maintenance Supervisor/desig	jnee	
					removed the four resident bed	S	
	Findings include:				from the second floor corridor		
					outside resident sleeping roon	า 84	
		ons with the Maintenance			to meet set standards. The		
		initial walk through of the			Administrator verified the work	con	
		on 04/15/25, four resident beds			04-30-2025.		
		econd floor corridor outside			0 All marrial and 1 H 1 5	1	
	resident sleeping Ro				2. All residents and all staff an		
		ne Maintenance Director at			visitors have the potential to b	е	
	-	25, the four resident beds were			affected but none were.		
		cond floor corridor outside			2 On 04 20 2025 tha		
		oom 84 with each bed			3. On 04-29-2025 the		
	projecting into the more than half of the width of the corridor. Based on interview at 2:26 p.m. on				Administrator in-serviced the	noo	
		tenance Director agreed the			Maintenance Supervisor/design and all other staff on the	ji i <del>ee</del>	
		ans of egress was not			requirement to ensure corridor	r	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155556	B. WI	NG		04/15/	/2025
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					IRGROUNDS RD		
WATERS	S OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON	I, IN 46072		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	continually maintain	ned free of all obstructions or			means of egress are continuo	usly	
	impediments to full	instant use in the case of fire			maintained to meet set	•	
	or other emergency.				standards Maintenance		
					Supervisor/all staff will ensure		
	These findings were	e reviewed with the			corridor means of egress are		
	_	he Maintenance Director			continuously maintained as a	oart	
	during the exit conf				of the facility's monthly Prever		
					Maintenance Program and	• •	
	3.1-19(b)				document those inspection res	uilte	
	(0)				as appropriate. If any issues a		
					discovered, they will be address		
					and resolved immediately. The		
					Maintenance Supervisor/desig		
					will review with the Administra		
					the inspection results.	lOi	
					4. The Administrator will mor	itor	
					adherence to the Preventative		
					Maintenance schedule and		
					validate the Preventative		
					Maintenance documentation is	s In	
					place.		
					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 month	-	
					Quality Assurance/Performand		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed by	ру	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	S	
					deemed necessary to ensure		
					compliance is maintained.		

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, ´		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING			LETED
		155556	B. W	ING		04/15	/2025
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD  300 FAIRGROUNDS RD  TIPTON, IN 46072				
(X4) ID	SUMMARY S	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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
K 0345	NFPA 101						
SS=C	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	-					
	Based on observation	on and interview, the facility	K 0	345	It is the intent of the facility to		05/09/2025
	failed to maintain the fire alarm system to ensure				ensure to maintain the fire ala	rm	
	that it had accurate	time and date information in			system to ensure it has accura	ate	
		requirements of NFPA 101,			time and date information in		
		ons 19.3.4 and 9.6 and NFPA 72,			accordance with the requirement	ents	
		ons 14.1 and 14.1.1. This			of NFPA 101, 2012 edition,		
	_	ould affect all residents, staff			sections 19.3.4 and 9.6 and N	FPA	
	and visitors.				72, 2010 edition, Sections 14.	1	
					and 14.1.1 to meet set standa	rds.	
	Findings include:			1. On 04-28-2025 the facilitie	the facilities		
					licensed fire alarm		
		ons with the Maintenance			contractor/maintenance		
	-	n. on 04/15/25, the main fire			supervisor/designee made rep	oairs	
	_	in the first floor electrical room			to the main fire alarm system		
		as 1:19 p.m. at 2:09 p.m.			control panel in the first floor	-	
		at 2:09 p.m. on 04/15/25, the			electrical room and corrected	the	
		or agreed the main fire alarm			time of day to meet set		
		el for the facility displayed the			standards. The Administrator		
	incorrect time of da	y.			verified the work on 04-30-202		
					2. a.All residents and all stat		
	These findings were				and visitors have the potential	to	
		he Maintenance Director			be affected but none were.		
	during the exit conf	erence.			/p>		
	2.1.10(1)				3. On 04-29-2025 the		
	3.1-19(b)				Administrator in serviced the		
					Maintenance Supervisor/desig	gnee	
					on the requirement to ensure		
					proper maintenance of the fire	;	
					alarm system to meet set		
					standards.Maintenance		
					Supervisor/Licensed Fire Alar		
					Contractor/designee will ensur		
					proper maintenance of the fire	<b>:</b>	
					alarm system as a part of the		
					facility's Preventive Maintenar		
					Program and document those		
					Linspection results as appropria	ate –	I

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	r í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/15/2025	
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					If any issues are discovered, will be addressed and resolve immediately. The Maintenand 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 in place.  4. The inspection results will presented by the Maintenance Supervisor/designee to the Administrator and the Administrator will present the inspection results at the monto Quality Assurance/Performant 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.	s in  be  thly  ce  d.  by  n	
K 0361 SS=E Bldg. 01	failed to ensure 1 o separated from the of resisting the pass sprinklered building 19.3.6.1(7). LSC 1	Open to Corridor  on and interview, the facility f 1 therapy rooms were corridor by a partition capable sage of smoke as required in a g, or met an Exception per 9.3.6.1(7) states that spaces leeping rooms, treatment	K 0	361	It is the intent of the facility to ensure therapy rooms are separated from the corridor by partition capable of resisting t passage of smoke as required sprinklered building, or met an exception per 19.3.6.1(7) to met an exception per 19.3.6.1(7	he d in a n	05/09/2025

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155556	B. W	ING		04/15	/2025
		1		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			IRGROUNDS RD		
WATERS	S OF TIPTON SKILL	LED NURSING FACILITY, THE			N, IN 46072		
WAILN	- III ION ONILI	LLD NOROING LACILITY, THE	_	111 101	1, 111 10012		
(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 APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ous areas shall be open to the			set standards.		
		ted in area, provided: (a) The			1. On 04-29-2025 the		
	_	which the space opens onto			Maintenance Supervisor/desi	gnee	
		compartment are protected by			installed positive latching		
		rvised automatic smoke			mechanism to each door in th		
		accordance with 19.3.4, and			door set to the Therapy Room		
	(b) Each space is protected by an automatic				across from the Laundry Rooi	n to	
	sprinklers, and (c) The space does not to obstruct				meet set standards. The		
	_	exits. This deficient practice			Administrator verified the repa	air on	
		residents, staff and visitors in			04-30-2025.		
	the vicinity of the T	Therapy Room on the first floor.			All residents and all staff a		
					visitors have the potential to b	e	
	Findings include:				affected but none were. The		
					Maintenance Supervisor/desi		
		ons with the Maintenance			inspected all doors and found	no	
	_	n. on 04/15/25, the corridor door			other negative findings.		
		Room across from the Laundry			3. On 04-29-2025 the		
	-	pped with a positive latching			Administrator in serviced the		
		each door in the door set into			Maintenance Supervisor/All st	taff	
		e corridor door set served as 1			on the requirement to ensure		
		e Therapy Room and was not			positive latching mechanisms		
		latching hardware. Based on			installed to the Therapy Room	n to	
	_	m. on 04/15/25, the			meet set standards.		
		tor agreed the corridor door set			![endif]>Maintenance		
		m was not equipped with			Supervisor/designee will ensu		
	_	evices to secure the door set			positive latching mechanisms		
		and to ensure the treatment			installed to the Therapy Room	n as	
	room was not open	to the corridor.			a part of the facility's Monthly		
					Preventive Maintenance Prog		
	_	e reviewed with the			and document those inspection		
		the Maintenance Director			results as appropriate. If any		
	during the exit conf	terence.			issues are discovered, they w	ill be	
					addressed and resolved		
	3.1-19(b)				immediately. The Maintenand		
					Supervisor/designee will revie	•W	
					with the Administrator the		
					inspection results.		
					![endif]>The Administrator	will	
					monitor adherence to the		
	1				Preventative Maintenance		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/15/2025
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD INGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0761 SS=E	NFPA 101 Maintenance, Insp	pection & Testing - Doors		schedule and validate the Preventative Maintenance documentation is in place.  The inspection results wipresented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont 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.	hly ce J. by
Bldg. 01	interview; the facili inspection and testin were completed in a Communicating oper required by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D	riew, observation and ty failed to ensure annual ng of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers 1.1 shall be permitted only in the protected by approved or assemblies. (See also Section penings required to have a fire Table 8.3.4.2 shall be tred, listed, labeled fire door window assemblies and their ware, including all frames, thorage, and sills in trequirements of NFPA 80, toors and Other Opening as otherwise specified in this	K 0761	It is the intent of the facility to ensure an annual inspection a testing of all fire door assemb is completed in accordance w LSC 19.1.1.4.1.1 to meet set standards.  1. On 07-23-2024 the certif fire door contractor/Maintenar Supervisor conducted the anrinspection of the rolling fire do and documented the results in Life Safety Binder to meet set standards. The Administrator verified the work on 04-30-2022. All residents and all staff a visitors have the potential to be affected but none were.	and lies iith  iied nce nual pors n the iii.

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	PROVIDER OR SUPPLIEF	LED NURSING FACILITY, THE		STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Code. NFPA 80 5.2	2.1 states fire door assemblies			3. /a>		
	shall be inspected a	and tested not less than			![endif]>Maintenance		
	annually, and a wri	tten record of the inspection			Supervisor/designee will ensu	re an	
	shall be signed and kept for inspection by the				annual inspection and testing		
	_	2.3.1 states functional testing of			rolling fire doors is completed		
		ow assemblies shall be			documented as a part of the		
		iduals with knowledge and			facility's annual Preventive		
		e operating components of			Maintenance Program and		
	_	ing subject to testing. NFPA			document those inspection re-	sults	
		re door assemblies shall be			as appropriate. If any issues		
	·	from both sides to assess the			discovered, they will be addre		
	overall condition of				and resolved immediately. Th		
					Maintenance Supervisor/desig		
	NFPA 80. Section 5	5.2.4.2 states as a minimum, the			will review with the Administra	_	
	following items sha				the inspection results.	ioi	
		or breaks exist in surfaces of			![endif]>The Administrator	will	
	either the door or fr				monitor adherence to the	******	
		light frames, and glazing beads			Preventative Maintenance		
		rely fastened in place, if so			schedule and validate the		
	equipped.	cry fastened in place, it so			Preventative Maintenance		
		e, hinges, hardware, and					
		reshold are secured, aligned,			documentation is in place.	ho	
		er with no visible signs of			4. The inspection results will be presented by the Maintenance		
	damage.	er with no visible signs of			presented by the Maintenance Supervisor/designee to the	;	
	(4) No parts are mis	ssing or broken					
		s do not exceed clearances			Administrator monthly and the	;	
	listed in 4.8.4 and 6				Administrator will present the inspection results at the montle	bly	
		g device is operational; that is,			Quality Assurance/Performan	•	
		apletely closes when operated					
	from the full open p				Improvement (QA/PI) meeting	•	
					Inspection results and system		
		is installed, the inactive leaf			components will be reviewed	υy	
	closes before the ac				the QA/PI Committee with	_	
		are operates and secures the			subsequent plans of correction		
	door when it is in the	-			developed and implemented a	IS	
	` '	vare items that interfere or			deemed necessary to ensure		
		are not installed on the door or			compliance is maintained.		
	frame.	~					
		fications to the door assembly					
	_	ed that void the label.					
	(11) Gasketing and	edge seals, where required, are					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155556		 JILDING	01	COMPLETED 04/15/2025		
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	300 FAI	ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	residents, staff and first floor dining roof Findings include:  Based on record revand the Maintenance O4/15/25, rolling fir documentation with month period was non interview at 12:3 Maintenance Direct rolling fire door in to inspection and testin most recent twelves available for review stated there may be rolling fire door by also stated it could be observations with the 1:34 p.m. on 04/15/fire door in the kitch the open dining roof floor main entrance. The dining room was inspection and testin located on the rolling interview at 1:34 p.m. Maintenance Direct testing documentation.	their presence and integrity. ice could affect over 20 visitors in the vicinity of the om.  The with the Administrator to be Director at 12:38 p.m. on the door inspection and testing the testing that the most recent twelve to available for review. Based the p.m. on 04/15/25, the tor stated the facility has one the kitchen and rolling fire dooring documentation within the month period was not to the Maintenance Director a hanging tag affixed to the an inspection contractor but thave been removed. Based on the Maintenance Director at 25, the facility has one rolling then separating the kitchen from month first floor in the first lobby smoke compartment. The month period was not the corridor. Noting documentation could be the grief of the corridor. Based on the month period was not the corridor. Noting documentation could be the grief of the corridor. Based on the month period was not to the corridor. Noting documentation could be the grief of the corridor of the rolling fire door in the most recent twelve month the most recent twelve month		CROSS-REFERENCED TO THE APPROPRIAT	TE	
	These findings were Administrator and t during the exit conf	he Maintenance Director				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY  COMPLETED  04/15/2025		
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COE AIRGROUNDS RD N, IN 46072	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ETION ILD BE ROPRIATE	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems Testing Based on record rev failed to ensure doc receptacle testing for was completed in an NFPA 99, Health C Edition, Section 6.3 listed as hospital-gra and in locations who anesthesia shall be re exceeding 12 month Facilities Code, 201 states hospital-grad performed after init servicing of the dev Receptacle Testing the physical integrific confirmed by visual the grounding circuits hall be verified. Coneutral connections shall be confirmed; grounding blade of (except locking-typ) than 115 grams (4 c states, at a minimum date, the rooms or a of which items have the performance receptacle. This could affect all Findings include:  Based on review of Log" documentation	riew and interview, the facility umentation of electrical outlet or all resident sleeping rooms ecordance with NFPA 99. are Facilities Code, 2012 .4.1.3 states receptacles not ade at patient bed locations ere deep sedation or general tested at intervals not as. NFPA 99, Health Care .2 Edition, Section 6.3.4.1.1 ereceptacles testing shall be ital installation, replacement or ice. Section 6.3.3.2, in Patient Care Rooms requires by of each receptacle shall be a inspection. The continuity of it in each electrical receptacle correct polarity of the hot and in each electrical receptacle and retention force of the each electrical receptacle ereceptacles) shall be not less sounces). Section 6.3.4.2.1.2 in, the record shall contain the reas tested, and an indication erect, or have failed to meet, quirements of this chapter. I residents, staff and visitors.	K 0914	It is the intent of the facili ensure documentation of outlet receptacle testing resident sleeping rooms completed in accordance NFPA 99 to meet set stat.  1. On 04-28-2025 the Maintenance Supervisor completed the annual restroom receptacle testing in itemizing the room location the receptacle locations in room to meet set standard. The Administrator verified 04-30-2025.  2. All residents and all states visitors have the potential affected but none were.  3. On 04-29-2025the Administrator in-serviced Maintenance Supervisor/ on the requirement the analysis electrical receptacle testing be completed annually and itemizing the room location the receptacle locations in room and documented in safety binder to meet set standards.  ![endif]>Maintenance Supervisor/designee will the annual electrical receptacle testing must be completed annually and include items.	relectrical for all is a with indards.  sident including on and in each rds. d the work  taff and il to be  the designee innual ing must ind include on and in each it the life  ensure eptacle ad inizing the	05/09/2025
	and the Maintenanc	lly)" with the Administrator e Director at 12:36 p.m. on receptacle inspection and		room location and the red locations in each room as the facility's annual Preve	s a part of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/15/2025			
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  testing documentation for all resident sleeping rooms within the most recent twelve month period was incomplete. The 01/01/25 inspection and testing documentation did not itemize the room location and did not itemize receptacle locations in each room. The 01/01/25 inspection and testing documentation grouped resident sleeping rooms together under "Room Location" as "RM 1-12", "RM 13-28", "RM A & B", "RM 29-40", "RM 42-54", "RM 55-65", "RM 66-78" and "RM 79-90". Based on interview at 12:36 p.m. on 04/15/25, the Maintenance Director stated each resident sleeping room may have a mix of hospital grade and non-hospital grade receptacles installed in the room but agreed the 01/01/25 annual receptacle inspection and testing documentation was not itemized by receptacle location.  These findings were reviewed with the		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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.  ![endif]>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the		(X5) COMPLETION DATE	
K 0918 SS=F Bldg. 01	-	s - Essential Electric Syste	K 0918	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.  It is the intent of the facility to	ce J. by n as	05/09/2025	
	failed to ensure 1 of allowed a 5 minute test. LSC 19.2.9.1 a	2 1 emergency generators was cool down period after a load refers to LSC 7.9 which refers to requires emergency generators	K 0918	ensure to emergency generate are allowed a 5 minute cool do period after a load test to mee standards.	ors own	03/09/2023	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/15/2025 155556 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 FAIRGROUNDS RD WATERS OF TIPTON SKILLED NURSING FACILITY, THE **TIPTON. IN 46072** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE providing power to emergency lighting systems to On 04-28-2025 the be installed, tested and maintained in accordance Maintenance Supervisor/designee with NFPA 110, Standard for Emergency and conducted the monthly load Standby Power Systems. NFPA 110, 2010 Edition, testing for the facility's diesel fuel Section 6.2.10 Time Delay on Engine Shutdown fired emergency generator and requires a minimum time delay of 5 minutes shall included a 5 minute cool down be provided for unloaded running of the time and documented the results Emergency Power Supply (EPS) prior to shutdown in the Life Safety Binder to meet to allow for engine cool down. This time delay set standards. The Administrator shall not be required on small (15 kW or less) verified the work on 04-30-2025. air-cooled prime movers. NFPA 110, Section 8.3.4 2. All residents and all staff and states a permanent record of the Emergency visitors have the potential to be Power Supply Systems (EPSS) inspections, tests, affected but none were. exercising, operation, and repairs shall be 3. On 04-29-2025 the maintained and readily available. This deficient Administrator in serviced the practice could affect all residents, staff and Maintenance Supervisor/designee visitors. on the requirement to ensure to conduct proper maintenance and Findings include: testing of the emergency electrical generator including conducting the Based on review of "Emergency Generator monthly load testing with a Monthly Test Log" documentation for the most minimum cool down time of 5 recent twelve month period with the Maintenance minutes to meet set standards. Director at 12:30 p.m. on 04/15/25, monthly load !--[endif]-->The Maintenance testing documentation for the facility's diesel fuel Supervisor will ensure to conduct fired emergency generator did not include a cool proper maintenance and testing of down time for a minimum of 5 minutes. The the emergency electrical generator monthly load test cool down time was including conducting the monthly consistently documented as "200 seconds" which load testing with a minimum cool is less than 5 minutes. Based on interview at 12:30 down time of 5 minutes as a part p.m. on 04/15/25, the Maintenance Director stated of the facility's monthly Preventive there has been no change to the length of the Maintenance Program and minimum cool down time for monthly load testing document those inspection results and agreed the documented cool down time was as appropriate. If any issues are less than 5 minutes. discovered, they will be addressed and resolved immediately. The These findings were reviewed with the Maintenance Supervisor/designee

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Administrator and the Maintenance Director

during the exit conference.

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will review with the Administrator

the inspection results. The Administrator will monitor

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/15/2025
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3.1-19(b)			adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation i place.  4. The inspection results will presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correctio developed and implemented a deemed necessary to ensure compliance is maintained.	s in be e hly ce g. by
K 0921 SS=F Bldg. 01	interview; the facili required maintenand documentation of it Related Electrical Eleath Care Faciliti 10.3 and 10.5 states resistance, leakage tests for fixed and prequired in 10.3. To with policies and propatient care rooms in 10.3.5.4 or 10.3.6 beafter any repair or reconsisting of several	riew, observation and ty failed to conduct the ce and maintain complete aspections for all Patient Care equipment (PCREE). NFPA 99, es Code, 2012 edition, sections the physical integrity, current, and touch current ortable PCREE is performed as sting intervals are established otocols. All PCREE used in setsted in accordance with effore being put into service and modification. Any system I electrical appliances liance with NFPA 99 as a	K 0921	It is the intent of the facility to ensure to conduct the require maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standard. On 04-28-2025 the facilitie trained Regional Property Managers will conduct PCRE testing on the other PCREE in facility including: electric beds nebulizers, oxygen concentra vital sign monitors, and other electrical medical equipment in meet set standards. The	ds. s E n the s, tors,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/15/2025			
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
PREFIX	complete system. So and procedures provinclude information are considered in the for electrical equipment instruction are readily available condensed operating appliance are legible equipment tests, reprovince in accomposition of the process of t	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION dervice manuals, instructions, wided by the manufacturer as required by 10.5.3.1.1 and the development of a program ment maintenance. Electrical cons and maintenance manuals to an advantage and safety labels and to an advantage and modifications is the end of time to demonstrate redance with the facility's asponsible for the testing, the of electrical appliances training. This deficient the facility.  The with the Administrator the Director at 12:37 p.m. on the esting documentation was not as a maintenance Director agreed to a mentation was not available to observations with the contact of the program	PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Administrator verified the work 04-30-2025.  2. All residents and all staff a visitors have the potential to be affected but none were.  3. On 04-29-2025 the Administrator in serviced the Maintenance Supervisor/design to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards. Maintenance Supervisor/designee will ensure testing of the PCREE is conducted and documented on PCREE equipment as a part of facility's annual Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addressed in the Administrator will monitor and the preventative with the Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation in place.  4. The inspection results will presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month of the preventation of the preventat	completion DATE  k on Indice  gree  gree  are essed the gree eator  are the same that are the second the gree eator  are the same that are the second the gree eator  are the same that are the		
	3.1-19(b)			Quality Assurance/Performan Improvement (QA/PI) meeting	ce		

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	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
				Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	1	

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