PRINTED: 10/29/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039		
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155202	B. WING		10/15/2024		
WATERS	PROVIDER OR SUPPLIER	LE, THE	1601 H GREE	ADDRESS, CITY, STATE, ZIP COD HOSPITAL DR NCASTLE, IN 46135			
(X4) ID		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			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 10/15 Facility Number: 0 Provider Number: 100 At this Emergency Waters of Greencas with Emergency Production and Suppliers, 42 C The facility has a caund had a census of	5/24 00109 155202 266290 Preparedness survey, The ttle was found in compliance eparedness Requirements for caid Participating Providers	E 0000	Preparation and/or execution this plan of correction in gene or this corrective action in particular does not constitute admission or agreement by the 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. The plan of correction constitutes credible allegation of compliance with all regulatory requirement our date of compliance is Oct 25, 2024. This provider respectfully request that this 2 Plan of Correction be consider the Letter of Credible Allegatic Compliance and requests a direview in lieu of a post survey review on or after October 25 2024.	ral, an ais e c c d e This our nce ts. tober 2567 ared on of esk		
Bldg. 01	Licensure Survey w	00109	K 0000	Preparation and/or execution this plan of correction in gene or this corrective action in particular does not constitute admission or agreement by th facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific	ral, an is e		

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

TITLE

(X6) DATE

Jennifer Etienne Administrator 10/24/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DY6621 Facility ID: 000109 If continuation sheet Page 1 of 8

PRINTED: 10/29/2024

						B NO. 0938-039
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPL 10/15/	ETED
			1601 H	ADDRESS, CITY, STATE, ZIP COD HOSPITAL DR NCASTLE, IN 46135		
(X4) ID PREFIX TAG	AN OF CORRECTION IDENTIFICATION NUMBER 155202 OF PROVIDER OR SUPPLIER ERS OF GREENCASTLE, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION AIM Number: 100266290 At this Life Safety Code survey, The Waters of Greencastle, was found not in compliance with 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 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 battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 65 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached equipment storage sheds which were not sprinklered. Quality Review completed on 10/16/24 NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) corrective actions are prepare and/or executed in compliance with state and federal laws. plan of correction constitutes credible allegation of compliance with all regulatory requirement Our date of compliance is October 25, 2024. This provider respectfully request that this Plan of Correction be consider the Letter of Credible Allegatic Compliance and requests a creview in lieu of a post survey review on or after October 25, 2024.	COMPLETION DATE ared ance . This es our diance nents. October is 2567 idered ation of a desk /ey		
K 0300 SS=F Bldg. 01	not sprinklered. Quality Review com NFPA 101 Protection - Other Based on record revobservation, the fact documentation for tof battery operated rooms was completed.	riew, interview, and ility failed to ensure he preventative maintenance smoke alarms in resident	K 0300	K300– It is the intent of the fato ensure documentation for preventative maintenance of battery operated smoke alarr resident rooms is complete to meet set standards.	the ns in	10/22/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

if not required by the Code, shall be maintained.

Fire-warning equipment shall be maintained and

NFPA 72, 29.10 Maintenance and Tests.

Event ID:

DY6621

Facility ID: 000109

TAKEN:

1 CORRECTIVE ACTIONS

On 10/22/2024 the

If continuation sheet

Page 2 of 8

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE ONLY IDENTIFICATION NUMBER A BUILDING STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITTAL DIR GREENCASTLE, IN 46135 TAG SUMMARY STATEMENT OF DEPICIENCIE (RACH DEPICIENCY MUST BE PRECEDED BY PULL TAG 1850 REGULATORY OR SEE DIRECTIVENIS INFORMATION 1850 REGULATORY OR SEE PRECEDED BY PULL TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEE PRECEDED BY PULL PREFIX TAG 1850 REGULATORY OR SEED REGUL	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIER		1601 H	ADDRESS, CITY, STATE, ZIP COD OSPITAL DR ICASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	E, THE 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) b 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 w be presented by the Maintenan 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 if 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.	rill ince hly ce J. by	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	failed to provide an returning cooking a when the kitchen ho was designed and in	on and interview, the facility approved method for ppliances to where they were bod extinguishing equipment astalled for 1 of 1 kitchen hood m. NFPA 96 Standard for	K 0324	Our date of compliance is 10/22/2024. K324— It is the intent of the facto ensure to provide an approximethod for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was	ved	10/25/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Ventilation Control and Fire Protection of

Event ID:

DY6621

Facility ID: 000109

If continuation sheet

designed and installed for kitchen

Page 4 of 8

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION DENTIFICATION NUMBER 155202 NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE WATERS OF GREENCASTLE, THE CALID SIMMARY STATEMENT OF DESCLICULE (REACH DEPICIENCY MUST BE PRECEDED BY PULL TAG Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the design of the fire extinguishing system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system sellent or extinguishing system sellent or servicing appliances are returned to approved design plocation prior to cooking operations, and any disconnected fire-extinguishing system mozeles attached to the appliances are reconnected in accordance with the manufacturer's listed design mamual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 5 staff, and no residents. The findings include: Based on observations and interview during a tour of the facility with the Administrator and Maintenance Director on 10/15/24 between 12:35 pm. and 148 pm. the electric for burner range, griddle and tabletop fiver to meet set standards. The findings include: Based on observations and interview during a tour of the facility with the Administrator that would ensure that the appliances were returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Administrator, the facility was not aware an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Administrator, the facility was not aware an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Administrator, the facility was not aware an approved design location after it had been moved for maintenance and cleaning.			X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
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returned to an approved design location after as appropriate. If any issues are						_	culte	
I maintenance or cleaning		maintenance or clea				1		
		mannenance or clea	anng.			and resolved immediately Th		

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

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/15/2024
	PROVIDER OR SUPPLIE S OF GREENCAST		1601 H	ADDRESS, CITY, STATE, ZIP COD IOSPITAL DR NCASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OI This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Eviewed with the Administrator Director at the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) Maintenance Supervisor/desig will review with the Administration the inspection results. b. The Administrator will monical adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is place. 4. MONITORING CORRECTIVACTION: a. The monitoring results will be presented by the Administrator 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 a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	nee tor ttor in in in in in in in in in i
K 0351 SS=E Bldg. 01	failed to maintain t Memory Springs so NFPA 13, Standard Systems. NFPA 13 states plates, escuto	- Installation on and interview, the facility he ceiling construction in 1 of 1 piled utility in accordance with I for the Installation of Sprinkler 3, 2010 edition, Section 6.2.7.1 Theons, or other devices used or space around a sprinkler shall	K 0351	Cur date of compliance is 10/25/2024. K351 - It is the intent of the facto ensure to maintain the ceilir construction in Memory Spring soiled utility in accordance with NFPA 13, Standard for the Installation of Sprinkler System to meet set standards	ng is n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DY6621

Facility ID: 000109

If continuation sheet

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

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155202	B. W	ING		10/15	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				OSPITAL DR		
WATERS	OF GREENCASTI	LE, THE			NCASTLE, IN 46135		
			1		, 2.22		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	· ·	be listed for use around a			1 CORRECTIVE ACTIONS	>	
	-	cient practice could affect staff one smoke compartment.			TAKEN: a On 10/16/2024 the		
	and 20 residents in	one smoke compartment.				nnoo	
	Findings include:				Maintenance Supervisor/designstalled the escutcheon ring i		
	r manigs metade.				the utility room across the cor		
	Based on observation	on with the Administrator and			from the nurse station in mem		
		rector on 10/15/24 at 12:59			springs to meet set standards	•	1
		n the soiled utility room across			The Administrator verified the		
	* . *	e nurse station in Memory			on 10/16/2024 .	.,	
		ng escutcheon. Based on			2 ALL OTHERS WITH		
		e of observation, the			POTENTIAL TO BE AFFECTI	ED:	
		or confirmed the escutcheon			a All residents and all staf		
		ould have it replaced.			and visitors have the potential		
		•			be affected but none were.		
	This finding was re	viewed with the Administrator			3 MEASURES TO PREVE	NT	
	_	irector at the exit conference.			REOCCURRENCE:		
					a On 10/16/2024 the		
	3.1-19(b)				Administrator in serviced the		
					Maintenance Supervisor/desig	gnee	
					to ensure to maintain ceiling		
					construction including the		
					sprinkler head escutcheon ring	gs to	
					meet set standards.		
					b Maintenance		
					Supervisor/designee will ensu	re to	
					maintain ceiling construction		
					including the sprinkler head		
					escutcheon rings as a part of	the	
					facility's Monthly Preventive		1
					Maintenance Program and		
					document those inspection re-		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig	-	1
					will review with the Administra	ιιοτ	
					the inspection results.		
					c The Administrator will monitor adherence to the		
	i				i monijor agnerence jo ine		1

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

PRINTED: 10/29/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUIL			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 10/15/2024				
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE		16	01 H	DDRESS, CITY, STATE, ZIP COD DSPITAL DR CASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results with the presented by the Maintenant 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 the QA/PI Committee with subsequent plans of correction developed and implemented at 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 10/18/2024.	nce hly ce by	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DY6621 Facility ID: 000109 If continuation sheet Page 8 of 8