STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155202	A. BUILDING -- B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/15/24 Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290 At this Emergency Preparedness survey, The Waters of Greencastle was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 100 certified beds and had a census of 65 at the time of this visit. Quality Review completed on 10/16/24	E 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 25, 2024. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 25, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/15/24 Facility Number: 000109 Provider Number: 155202	K 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific	

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.

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	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		corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 25, 2024. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 25, 2024.	
K 0300 SS=F Bldg. 01	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 existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and	K 0300	**K300**– It is the intent of the facility to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms is complete to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 10/22/2024 the	10/22/2024

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	tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review and interview with the Maintenance Director and Administrator on 10/15/24 between 10:00 a.m. and 12:35 p.m., itemized list for preventative maintenance of resident room battery operated smoke alarms was available for review. The documentation provided showed weekly testing and periodic cleaning, but no records were available to show when the batteries are changed. Based on interview at the time of review, the Administrator stated the battery operated smoke alarms have 9-volt batteries. The Maintenance Director stated the alarms are tested weekly and the batteries are changed when needed. Based on observations between 12:35 p.m. and 1:48 p.m. during a tour of the facility with the Administrator and Maintenance Director, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Supervisor/designee performed the weekly testing of the resident room battery operated smoke alarms and recorded when the batteries were changed to meet set standards. The Administrator verified the work on 10/22/2024. b On 10/22/2024 the Maintenance Supervisor/designee replaced all battery-operated smoke alarms in resident rooms, including the batteries to meet set standards. The Administrator verified the work on 10/22/2024. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained and tested per manufactures guidelines including recording when the batteries are changed and will document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

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			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 will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/22/2024.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of	K 0324	**K324**– It is the intent of the facility to ensure to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for kitchen	10/25/2024

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	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 system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. 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 p.m. and 1:48 p.m., the electric 6 burner range, griddle and tabletop electric fryer were located on the cooking line under the hood in the kitchen were not provided with an approved method 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 method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning.		hood extinguishing system to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 10/24/2024 the Maintenance Supervisor mapped and taped off the approved location on the floor for the electric 6 burner range, griddle and tabletop electric fryer locked in the kitchen to meet set standards. The Administrator verified the work on 10/24/2024. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator in serviced the Maintenance Supervisor/Dietary Manager and all dietary staff on the proper location in the kitchen for the electric 6 burner range, griddle and tabletop fryer to meet set standards. b. The Maintenance Supervisor and Dietary Manager will ensure all kitchen staff are instructed on the proper location for the electric 6 burner range, griddle and tabletop electric fryer as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The	

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Supervisor/designee will review with the Administrator the inspection results. 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 monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/25/2024.**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Memory Springs soiled utility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall	K 0351	**K351** - It is the intent of the facility to ensure to maintain the ceiling construction in Memory Springs soiled utility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to meet set standards.	10/18/2024

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	be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and 20 residents in one smoke compartment. Findings include: Based on observation with the Administrator and the Maintenance Director on 10/15/24 at 12:59 p.m., the sprinkler in the soiled utility room across the corridor from the nurse station in Memory Springs had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing and would have it replaced. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**1 CORRECTIVE ACTIONS TAKEN**: a On 10/16/2024 the Maintenance Supervisor/designee installed the escutcheon ring in the utility room across the corridor from the nurse station in memory springs to meet set standards. The Administrator verified the work on 10/16/2024 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/16/2024 the Administrator in serviced the Maintenance Supervisor/designee to ensure to maintain ceiling construction including the sprinkler head escutcheon rings to meet set standards. b Maintenance Supervisor/designee will ensure to maintain ceiling construction including the sprinkler head escutcheon rings as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the	

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			Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/18/2024.**	