STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155233	A. BUILDING -- B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

(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: 12/14/22 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 At this Emergency Preparedness survey, The Waters of Batesville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 86 certified beds. At the time of the survey, the census was 65. Quality Review completed on 12/15/22	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
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: 12/14/22 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 At this Life Safety Code survey, The Waters of Batesville was found not in compliance with	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jalena Ball		12/23/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. 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 86 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the two story detached maintenance/laundry building. Quality Review completed on 12/15/22		**with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

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	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 12 hazardous areas such as combustible storage areas (over 50 square feet in size) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 12/14/22, resident sleeping Room 5 was converted to a storage room for combustible boxes, furniture and supplies. The corridor door to Room 5 was equipped with two self closing hinge devices on the door but the door failed to self close and latch into the door frame when tested to close multiple times. In addition, the corridor door to the brief storage room by the entrance to the main dining room was	K 0321	**K321**– It is the intent of the facility to ensure hazardous areas such as combustible storage areas were separated from other spaces by smoke resistant partitions and doors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ___12/15/2022 _____ the Maintenance Supervisor/designee 1. repaired the self-closing hinge devices on resident sleeping Room 5 to ensure it closes and latches fully into the frame 2. Repaired the door to the brief room to ensure the door would close and latch fully into the door frame to meet set standards. The Administrator verified the work on _____12/15/2022 _____ . **2. ALL OTHERS WITH**	12/15/2022

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	equipped with a self closing device but the door kept hitting the door frame when tested to close and would not fully self close and latch into the door frame. The brief room was being used for shelf storage of combustible boxes throughout the room. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On ____12/15/2022 _____ the Maintenance Supervisor/designee inspected all hazardous areas for self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On ___12/14/2022_____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that all hazardous areas must have self-closing devices to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure they have self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING**	

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			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 100% compliance is maintained.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke	K 0361	**K361** – It is the intent of the facility to ensure therapy rooms are separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an exception per 19.3.6.1(7) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ____12/15/2022_____ the	12/15/2022

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	detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 12/14/22, the corridor door set to the Therapy Room by the main entrance lobby was not equipped with latching hardware to latch the doors into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door set to the Therapy Room was not equipped with latching hardware to latch the doors into the door frame. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Supervisor/designee installed latching hardware to the corridor door set to the Therapy Room by the main entrance lobby to ensure it closes and latches fully into the door frame to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On ____12/15/2022 _____ the Maintenance Supervisor/designee inspected all corridor doors and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On __12/14/2022_____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that corridor doors must have hardware that latch and close and latch fully into the door frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure the latching hardware is working properly and the doors close and latch fully into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The	

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			Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the 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 100% compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ____12/15/2022 _____.**	