STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING -- B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITEWATER COMMONS SENIOR LIVING	215 W HIGH ST LIBERTY, IN 47353

(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: 06/20/23 Facility Number: 000510 Provider Number: 155507 AIM Number: 100285440 At this Emergency Preparedness survey, Whitewater Commons Senior Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 30. Quality Review completed on 06/26/23	E 0000		
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: 06/20/23 Facility Number: 000510 Provider Number: 155507 AIM Number: 100285440 At this Life Safety Code survey, Whitewater	K 0000	Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Blackmon	HFA	07/07/2023

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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	Commons Senior Living 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 one-story facility was determined to be of Type V (000) 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 60 and had a census of 30 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three detached wooden storage sheds which were not sprinkled. Quality Review completed on 06/26/23		Please accept this Plan of Correction as our credible allegation of compliance.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on interview, and observation, the facility failed to ensure propane tanks were stored properly away from all ignition sources. NFPA 58 specifies storage requirements including required separation distances for LP gas containers. This	K 0300	No residents or staff were affected but all residents and staff had the potential to be affected. The gas grill with attached propane tank located near the patio smoking	07/07/2023

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	deficient practice could affect 4 staff and 20 residents. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor on 06/20/23 between 12:45 p.m. and 3:45 p.m., the patio smoking area contained a gas grill with 1 propane tank attached. The Maintenance Supervisor acknowledged the LP tank was being stored in close proximity to the smoking area cigarette receptacle and the tank would need to be kept elsewhere. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 3.1-19(b)		area was removed. The Maintenance Director was re-educated on gas grill and propane tank placement. A new visual inspection form has been initiated for the Maintenance director to complete. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete a visual inspection of patio smoking area and document on inspection form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will conduct audit daily X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter, 5 days per week. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.	
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			

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	nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. 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 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 staff in the kitchen and 20 residents in the dining area. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor on 06/20/23 between 12:45 p.m. and 3:45 p.m., the corridor door to the kitchen from the dining area, equipped with a self-closing device, failed to self-close and latch into the door frame. The kitchen contained several large trash receptacles. This finding was acknowledged by the	K 0321	No residents were affected but all residents had the potential to be affected. The Corridor door to the kitchen was repaired to ensure self-closing device self-closed and latched into the door frame The maintenance director was re-educated on Hazardous Areas-corridor doors. A new visual inspection sheet has been initiated. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete Any negative findings will be corrected immediately and reported to the administrator, a visual inspection of the kitchen corridor door and	07/06/2023

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	Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 3.1-19(b)		document on inspection form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will conduct audit daily X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter 5 days per week. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the	K 0353	No residents or staff were affected but all residents and staff had the potential to be affected. Gardner Fire Protection company completed facility full hydrostatic	07/07/2023

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	Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on records review and interview with the Administrator and the Maintenance Supervisor from a sister facility on 06/20/23 between 10:25 a.m. and 12:45 a.m., the Internal Pipe Inspection Letter from the facilities vendor dated 5/29/19 stated the facility contractor "performed a 5-year Internal Pipe Inspection at Whitewater Commons located at 215 West High Street, Liberty IN 47353 on 05/17/19. Minor to excessive debris found in cross mains of sprinkler lines throughout the whole building. Recommend flushing cross mains of debris." After interview, the facility began a fire watch and contacted a new contractor who sent a representative. A technician from the aforementioned contractor was onsite at the time of the survey exit. This finding was acknowledged by the Administrator and Maintenance Supervisor at the		flush for automatic sprinkler system and replaced the sprinkler head in the cooler. The Maintenance Director was re-educated on Required Sprinkler System Maintenance and Testing. A new visual inspection sheet has been initiated. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete visual inspection form and report Any negative findings will be corrected immediately and reported to the administrator. Monitoring will conduct audit daily X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter 5 days per week . Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing	

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	time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the cooler was maintained. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 staff in the kitchen area. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor on 06/20/23 between 12:45 p.m. and 3:45 p.m., the sprinkler head in the cooler was leaking. Based on interview at the time of observation, the Maintenance Supervisor wiped the sprinkler head and agreed the sprinkler head in cooler was leaking. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 3.1-19(b)			

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the MDS office. Findings include:	K 0920	No residents or staff were affected but all residents and staff had the potential to be affected. The power strip was removed from the MDS office and the flexible cord was removed from the attic. The Maintenance Director was re-educated on Electrical Equipment-Power cords and Extension cords. A new visual inspection form has been initiated.	07/06/2023

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	Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor on 06/20/23 between 12:45 p.m. and 3:45 p.m., in the MDS Coordinators office a power strip was being used to power a dorm style refrigerator (high power draw equipment). This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 15 occupants in one smoke compartment. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Supervisor on 06/20/23 between 12:45 p.m. and 3:45 p.m., in the attic near the administrator's office, a light switch was being powered by a cord which was plugged into an outlet on the side of a ceiling light in the attic. The Maintenance Supervisor stated that this would be an easy fix and he was unaware of the plug being used to power the lights in the attic space.		As a means of quality assurance, the Maintenance Director or designee will be responsible to complete visual inspection form and report Any negative findings will be corrected immediately and reported to the administrator. Monitoring will conduct audit daily 5 times per week, weekly X 4 weeks, monthly X 4 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing	

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	This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of discovery and again at the exit conference with the Administrator Maintenance Supervisor and Regional Director of Operations all present. 3.1-19(b)			