PRINTED: 01/29/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION ID		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI		(X3) DATE SURVEY COMPLETED 01/14/2025		
	PROVIDER OR SUPPLIER OF NEW CASTLE			1000 N 16TH ST NEW CASTLE, IN 47362			
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
E 0000	conducted by the Ir accordance with 42 Survey Date: 01/14 Facility Number: 0 Provider Number: 100 At this Emergency Waters of New Cas with Emergency Pr Medicare and Mediand Suppliers, 42 C The facility has 66 the survey, the cens	M/25 000201 155304 266780 Preparedness survey, The tle was found in compliance eparedness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plat correction in general, or this corrective action, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepa and/or executed in complian with state and federal laws. This plan of correctio constitutes a written allegat of substantial compliance w Federal Medicare and Medicaid requirements. Requesting for paper compliance	the set ared noe		
K 0000							
Bldg. 01	Licensure Survey w Department of Hea 483.90(a). Survey Date: 01/14 Facility Number: 0 Provider Number: 100	00201 155304	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plat correction in general, or this corrective action, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepar	the s set		

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

(X6) DATE

TITLE

Brittney Longnecker 01/24/2025

Any defiency statement 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 disclodays 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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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/14/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362			
(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)	5.112	
	New Castle 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 is located in a three-story portion of an existing hospital with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility is located on the third story of the building. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and battery-powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 60 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 01/15/25		and/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance will Federal Medicare and Medicaid requirements. Requesting for paper compliance	on	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use	K 0291	K291 – It is the intent of the facility to ensure battery power emergency lighting systems as maintained in accordance with LSC Section 7.9 to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On1/15/25	re	
	and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 20 residents, staff and visitors.		Maintenance Supervisor/desig repaired the battery operated lighting system installed on the	nee	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01/14/2025 155304 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 N 16TH ST NEW CASTLE, IN 47362 WATERS OF NEW CASTLE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE corridor wall outside the Findings include: Maintenance Director's office near the corridor door set to the Based on observations with the Executive hospital on the third floor to meet Director and the Maintenance Director during a set standards. The Administrator tour of the facility from 12:10 p.m. to 1:10 p.m. on verified the work on _____ 1/15/25 01/14/25, the battery operated lighting system installed on the corridor wall outside the 2.ALL OTHERS WITH Maintenance Director's office near the corridor POTENTIAL TO BE AFFECTED: door set to the hospital on the third floor failed to 1.All residents and all staff illuminate when its respective test button was and visitors have the potential to pushed multiple times. Based on interview at the be affected but none were. time of the observations, the Maintenance **3.MEASURES TO PREVENT** Director agreed the battery operated lighting REOCCURRENCE: system failed to illuminate when tested multiple 1.On 1/15/25 times. Administrator inserviced the Maintenance Supervisor/designee These findings were reviewed with the Executive on the requirement to ensure to Director during the exit conference. maintain battery powered emergency lighting systems are 3.1-19(b) maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure to maintain battery powered emergency lighting systems are maintained as a part of the facility's monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. 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

3.The Administrator will

the inspection results.

monitor adherence to the Preventative Maintenance

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/14/2025	
	PROVIDER OR SUPPLIE S OF NEW CASTLE		1000 N	ADDRESS, CITY, STATE, ZIP COD N 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVACTION: 1.The inspection results who be 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 is1/15/25	vill nce lly se	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other	r				
	failed to replace ba installed in 35 of 30 accordance with N Edition, Section 14 testing, and mainte the requirements of equipment manufact Section 14.4.8.1 sta	on and interview, the facility ttery operated smoke alarms 6 resident sleeping rooms in FPA 72. NFPA 72, 2010 8.2.1.1.1 states inspection, nance programs shall satisfy f this Code and conform to the cturer's published instructions. ates unless otherwise the manufacturer's published	K 0300	k300– It is the intent of the factor to ensure to replace battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72 to moset standards. 1 CORRECTIVE ACTIONS TAKEN: a On1/15/25 the Maintenance Supervisor/desige	ed neet	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/14/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362				
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TAG	regulatory of instructions, single-alarms shall be repl to operability tests belonger than 10 year. This deficient pract staff and visitors. Findings include: Based on observation Director and the Mattour of the facility for 101/14/25, manufact the US Electric Mosmoke alarm install sleeping Room 358 they were each mar interview at the time Maintenance Direct same type of smoke sleeping room exce 360 which had a 10 alarm manufactured ceiling of that room time of the observations of the observations, the English at total of the conservations, the English as a total of the operation of the property of the property of the property of the property of the observations, the English as a total of the operations of the property of	end multiple-station smoke aced when they fail to respond but shall not remain in service is from the date of manufacture. Indeed, and multiple-station smoke aced when they fail to respond but shall not remain in service is from the date of manufacture. Indeed, and in the fact all residents, and in Room 12:10 p.m. to 1:10 p.m. on the ceiling in resident and in Room 362 indicated and in Room 362 indicated and in Room 362 indicated and in the facility has the centre at the facility has the end alarm installed in each put for resident sleeping Room resident sleeping rooms.	TAG	checked and inspected manufacturer's guideline battery powered smoke the resident rooms and it past the manufacturer's date, he replaced them a documented the installar in the Life Safety Manual set standards. The Administrator inserviced Maintenance Supervisor on the requirement to er battery operated smoke are maintained per manuguidelines to meet set sit b Maintenance Supervisor/designee will battery-operated smoke are maintained per manuguidelines and will documented the Battery-Operated Smoke are maintained per manuguidelines and will documented to be filed in the Life Safa as a part of the facility's Maintenance Program. issues are discovered, the addressed and resolved immediately. The Maint Supervisor/designee will with the Administrator the supervisor/designee will with the supervisor/designee will will supervisor/designee will will supervisor/designee will will supervisor/designee will supervisor/designee will supervisor/designee will super	es all the alarms in f any were ten-year and cion date I to meet cinistrator 1/15/25 HEECTED: II staff cential to re. REVENT the the cydesignee asure all alarms ufacturer's candards. ensure all alarms ufacturer's ment the corated concerated concernate concernat	

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155304	B. WING		01/14/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		1000 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA COMPI		
	REGOL/HORT O			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 who be presented by the Maintena 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/15/25	vill ance hly ce g. by n	

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