STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155304	A. BUILDING -- B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF NEW CASTLE, THE	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 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: 01/14/25 Facility Number: 000201 Provider Number: 155304 AIM Number: 100266780 At this Emergency Preparedness survey, The Waters of New Castle was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 66 certified beds. At the time of the survey, the census was 60. Quality Review completed on 01/15/25	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, 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. Requesting for paper compliance**	
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: 01/14/25 Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910 At this Life Safety Code survey, The Waters of	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, 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**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittney Longnecker		01/24/2025

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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	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 compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Requesting for paper compliance**	
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 and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 20 residents, staff and visitors.	K 0291	**K291** – It is the intent of the facility to ensure battery powered emergency lighting systems are maintained in accordance with LSC Section 7.9 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On ____1/15/25_____ the Maintenance Supervisor/designee repaired the battery operated lighting system installed on the	01/15/2025

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	Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 01/14/25, the battery operated lighting system installed on the corridor wall outside the Maintenance Director's office near the corridor door set to the hospital on the third floor failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the battery operated lighting system failed to illuminate when tested multiple times. These findings were reviewed with the Executive Director during the exit conference. 3.1-19(b)		corridor wall outside the Maintenance Director's office near the corridor door set to the hospital on the third floor to meet set standards. The Administrator verified the work on _____ 1/15/25 _____ . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On ___ 1/15/25 _____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to maintain battery powered emergency lighting systems are 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 Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.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 ___** 1/15/25____**.**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 35 of 36 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published	K 0300	**K300**– It is the intent of the facility to ensure to replace battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72 to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On ___1/15/25_____ the Maintenance Supervisor/designee	01/15/2025

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	instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:10 p.m. on 01/14/25, manufacturer's documentation affixed to the US Electric Model US1-1122L battery operated smoke alarm installed on the ceiling in resident sleeping Room 358 and in Room 362 indicated they were each manufactured 02/27/12. Based on interview at the time of the observations, the Maintenance Director stated the facility has the same type of smoke alarm installed in each sleeping room except for resident sleeping Room 360 which had a 10-year Kidde Model i9050 smoke alarm manufactured on 01/10/19 installed on the ceiling of that room. Based on interview at the time of the observations, the Maintenance Director agreed the manufacture date for most all resident sleeping room battery operated smoke alarms installed in the facility was more than ten years old. Based on interview at the time of the observations, the Executive Director stated the facility has a total of 36 resident sleeping rooms. These findings were reviewed with the Executive Director during the exit conference. 3.1-19(b)		checked and inspected per manufacturer's guidelines all the battery powered smoke alarms in the resident rooms and if any were past the manufacturer's ten-year date, he replaced them and documented the installation date in the Life Safety Manual to meet set standards. The Administrator verified the work on _____ 1/15/25 ____ . **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 ___1/15/25___ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure all battery operated smoke alarms are maintained per manufacturer's guidelines to meet set standards. b Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained per manufacturer's guidelines 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	

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			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 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**.**	