PRINTED: 10/19/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG E 0000	(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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42  Survey Date: 09/29  Facility Number: 0  Provider Number: 100  At this Emergency Waters of New Cas compliance with En Requirements for N Participating Provid 483.73  The facility has 66 the survey, the cens	00201 155304 266780  Preparedness survey, The tle was found in substantial mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR	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 facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepar and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance wifederal Medicare and Medicaid requirements.  We are requesting paper compliance.	the set red ce	
E 0029 SS=C Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),				

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

(c) The [facility] must develop and maintain an emergency preparedness communication

(X6) DATE

TITLE

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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155304	B. WING 09/29/202			/2022
		1	CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		I 16TH ST		
WATERS	OF NEW CASTLE	E, THE		CASTLE, IN 47362		
(VA) ID	CLIMMADA	CTATEMENT OF DEFICIENCIE				(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROP		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCIT		DATE
		s with Federal, State and				
		ist be reviewed and updated				
		ears [annually for LTC				
	facilities].	11.4 1 4 6 71.	F 0000			10/14/2022
		view and interview, the facility	E 0029	<b>E029</b> – It is the intent of the fac	-	10/14/2022
	_	nd maintain a complete		to ensure to develop and mair	itain	
		dness communication plan that		an emergency preparedness		
	_	eral, State, and local laws in		communication plan that comp		
		CFR 483.73(c). This deficient		with Federal, State and local la		
	practice could affect	et all occupants.	- I			
	F: 1: 1 1			least annually in accordance v		
	Findings include:			42 CFR 483.73 (a) to meet se	τ	
	D 1 1	· · · · · · · · · · · · · · · · · · ·		standards.		
		view with the Administrator		1) CORRECTIVE ACTIONS		
		Director on 09/29/22 between		TAKEN:		
		15 p.m., the provided EPP did not		a) On 10/5/22 the		
		tact information for all facility		Administrator and the		
		PP maintained by the		Maintenance Supervisor/design		
		in the EPP kept at the nurse's om the nurses station		reviewed and updated the faci	-	
		on the nurses station nformation for a previous		Emergency Preparedness Pol	-	
		ell as other facility personnel.		Manual at the nurses station a	IS	
		ew during records review, the		appropriate including current	i4. ,	
		ed that contact information in		contact information for all facil	ıty	
		PP plans did not match and		staff to meet set standards.  2) ALL OTHERS WITH		
	was not current.	i i pians did not maten and		1 '	ED:	
	was not current.			a) All residents and all state		
	The finding was rev	viewed with the Administrator		a) All residents and all state and visitors have the potential		
	_	Director at the time of discovery		be affected but none were. The		
		e exit conference at 3:00 p.m.		facility has only one Emergence		
	and again during th	e can comercine at 3.00 p.m.		Preparedness Policy Manual.	у	
				3) MEASURES TO PREVE	NT	
				REOCCURRENCE:	141	
				a) On _ 10/5/22 the		
				Administrator inserviced the		
				Maintenance Supervisor/desig	inee	
				on the requirement that the	,,,,,,,	
				facility's Emergency		
	I		I	I radiity a Enforgerios		I

Preparedness Policy Manual must be reviewed at least annually and

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. B		(2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					updated as frequently as necessary with documentation noting the reviews and change the Reviews and Revisions (p. 5) to meet set standards. b) On _ 10/5/22 the Administrator and the Maintenance Supervisor/design inserviced all staff on the update Emergency Preparedness Policy Manual Cortification Sheet to be filed each employee's personnel file meet set standards. c) The Administrator will monitor adherence to the Emergency Preparedness Policy Manual Certification Sheet to be filed each employee's personnel file meet set standards. c) The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) At least annually to enscompliance, the Administrator Maintenance Supervisor/design will review the Emergency Preparedness Policy Manual amake changes as necessary in meet set standards. Those reviews will be documented an appropriate. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _ 10/14/22 Requesting Paper	es on lage gnee ated licy lin le to licy licy and gnee and to s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09/29/2022				
	PROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP CO I 16TH ST CASTLE, IN 47362	D	
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
K 0000						
Bldg. 01	Licensure Survey we Department of Head 483.90(a).  Survey Date: 09/29  Facility Number: 09/29  Facility Number: 100  At this Life Safety of New Castle was for Requirements for Personal Medicare/Medicaid Life Safety from Finational Fire Protest Life Safety Code (In Health Care Occupation of The Saf	200201 155304 267910  Code survey, The Waters of and not in compliance with farticipation in 1, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.  ted in a three-story portion of with a basement was a Type II (222) construction and red. The facility is located on the facility has a fire first hard wired smoke detectors in the sopen to the corridors, and make detectors in all resident facility has a capacity of 66 and 53 at the time of this survey.	K 0000	DISCLAIMER STATEMI Preparation and/or exe of this plan of correctic general, or this correct action in particular, do constitute an admissio agreement by this facil facts alleged or conclu forth in this statement deficiencies. The plan correction and specific corrective actions are plandy or executed in con- with state and federal I This plan of correction constitutes a written al of substantial complian Federal Medicare and Medicaid requirements We are requesting pap compliance.	cution on in cive es not on or lity of the sions set of of prepared npliance aws. llegation nce with	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		155304	B. WI	NG		09/29	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	OF NEW CASTLE	THE			16TH ST		
WATERS	OF NEW CASTLE	, IHE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0211	NFPA 101						
SS=E	Means of Egress -	- General					
Bldg. 01	Means of Egress -	- General					
	Aisles, passagewa	ays, corridors, exit					
	discharges, exit lo	cations, and accesses are					
	in accordance with	n Chapter 7, and the means					
	of egress is contin	nuously maintained free of					
	all obstructions to	full use in case of					
	emergency, unles	s modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1	.10.1					
		on and interview, the facility	K 0	211	K211 – It is the intent of the		10/14/2022
	failed to ensure 2 of	f 5 means of egress was			facility to ensure to provide me	eans	
		ained free of all obstructions			of egress continuously mainta		
		full instant use in the case of			free of all obstructions or		
	_	ency. This deficient practice			impediments to full instant use	e in	
		residents, staff and visitors if			the case of fire or other		
	needing to exit the f				emergency to meet set standa	ards.	
	C	•			1. CORRECTIVE ACTION		
	Findings include:				TAKEN:		
	C				a. On10/5/22 the		
	Based on observation	on and interview with the			Maintenance Supervisor/desig	nee	
	Administrator and M	Maintenance Director on			1. removed the wheelchairs th		
	09/29/22 between 1	2:15 p.m. and 2:30 p.m., the			were being stored in the corrid	lor	
	following was noted				between resident room 362 &		
	a) during the initial	walk through of the facility			and 2. Removed the rope type	)	
		e conference, more than 8			strap barrier near stairwell nur		
		eing stored in the corridor			3 to meet set standards. The		
		oms 362 and 378. The			Administrator verified the remo	ovals	
	aforementioned who	eelchairs had been relocated			on _10/5/22		
	later in the day before	ore the facility tour.			2. ALL OTHERS WITH		
		mber 3, a rope type strap barrier			POTENTIAL TO BE AFFECTE	ED:	
		estrict access to the facility			a. All residents and all staf		
		ew at the time of discovery, the			and visitors have the potential	to	
		d that the barrier was in place			be affected but none were. O		
	to discourage elope	-			10/6/22 the		
	Based on interview				Maintenance Supervisor/desig	nee	
	observations, the A	dministrator agreed the			inspected all corridor means o		
		ans of egresses were not			egress and found no other		
		ained free of all obstructions			negative findings.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/29/2022				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)				
	(EACH DEFICIEN REGULATORY OR or impediments to f fire or other emerge The finding was rev and Maintenance D	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ull instant use in the case of		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ENT  a gnee  n et  ect for nce ate. they ed ce ew  will ance			
				inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting	ce			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  09/29/2022	
	ROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST	
WATERS	OF NEW CASTLE	, THE	NEW C	CASTLE, IN 47362	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special loc clinical security ne used, only one loc permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times.	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: SOR SECURITY THREAT king arrangements for the eds of the patient are eking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1,		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 wit all regulatory requirements. Our date of compliance is _10/14/22  Requesting Paper Complian	by n as
	∣ Where special loc	king arrangements for the			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155304		A. BUILDING <u>01</u> B. WING			COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIER OF NEW CASTLE		1000 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	the Clinical or Sec are being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended loc space); and both the systems are arrand upon activation.  18.2.2.2.5.2, 19.2. DELAYED-EGRESTARRANGEMENTSTAPPROVED, listed desystems installed in 7.2.1.6.1 shall be assemblies serving contents in building an approved, superfection system automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRANDACCESS-CONTR LOCKING ARRANDELEVATOR LOBEL LOC	elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised r system.  2.4  OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall  2.4  BY EXIT ACCESS				

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED			
		155304	B. WING		09/29/2022			
			CTREET	CADDRESS CITY STATE ZIR COD				
NAME OF I	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD					
WATED!	S OF NEW CASTLE	TUE	1000 N 16TH ST NEW CASTLE, IN 47362					
WATER	OF NEW CASTLE	-, INC	INEVV	CASTLE, IN 47302				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTI  PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL			COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	18.2.2.2.4, 19.2.2							
		on and interview, the facility	K 0222	K222– It is the intent of the facil	ity 10/14/2022			
		f 1 administrators office door		to ensure administrator's office				
	_	only one latching mechanism		door is provided with only one				
		and open. 33.2.2.5.7 refers to		latching mechanism to release t	the			
		ates a latch or other fastening		door and open to meet set				
		af shall be provided with a		standards.				
	_	at has an obvious method of		1. CORRECTIVE ACTIONS				
		s readily operated under all		TAKEN:				
	lighting conditions. 7.2.1.5.10.4 states the			a. On10/6/22 the				
	releasing mechanism shall open the door leaf with			Maintenance Supervisor/design	ee			
		releasing operation. 7.2.1.5.10.1		removed the second locking				
	_	mechanism for any latch shall		mechanism from the				
		than 34 inches, and not more		administrators office/conference	)			
	than 48 inches, abo	we the finished floor. This		room corridor door so door will				
	deficient practice c	ould affect 6 occupants in the		only have one locking mechanis	sm			
	office area.			to meet set standards. The				
				Administrator verified the work of	on			
	Findings include:			10/6/22				
				2. ALL OTHERS WITH				
		on and interview with the		POTENTIAL TO BE AFFECTED	<b>D</b> :			
		Maintenance Director on		a. All residents and all staff				
		12:15 p.m. and 2:30 p.m., the		and visitors have the potential to	0			
		ice/Conference room corridor		be affected but none were. On				
		with two latching devices, a		10/6/22 the Maintenance				
	_	e with a turn latching		Supervisor/designee inspected	all			
		eparate keyed claw type		doors to ensure it is provided wi				
	_	Administrator agreed that,		only one latching mechanism ar				
		it the Administrators		found no other negative findings				
		Room it would require two		2. MEASURES TO PREVEN	NT			
	separate actions to	open the door.		REOCCURRENCE:				
				a. On _10/6/22 the				
		cknowledged by the		Administrator inserviced the				
		tor and Field Maintenance		Maintenance Supervisor/design	ee			
		me of observation and again at		on the requirement that doors				
	the Exit Conference	e at 4:15 p.m.		must only have one latching				
	1		1	mechanism to meet set				

3.1-19(b)

standards.

Maintenance Supervisor/designee will inspect

## C

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EPARIMENT OF HEALTH AND HU	FORM APPROVED					
ENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED			
	155304	B. WING	09/29/2022			

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 N 16TH ST WATERS OF NEW CASTLE, THE NEW CASTLE, IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE all means of corridor doors to ensure they only have one latching mechanism 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. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. MONITORING **CORRECTIVE ACTION:** 

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

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CLI.ILINOTOI	THE WINDS	III SERVICES				0.11	21.0.0,00	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	A. BUILDING <u>01</u>		COMPLETED		
		155304	B. WING			09/29/	/2022	
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
			1000 N 16TH ST					
WATERS	OF NEW CASTLE	, IHE	I N	NEW CASTLE, IN 47362				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	T	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE	
					10/14/22 .			
					Requesting Paper Complian	ce		
					3 1/1 1 /			
K 0321	NFPA 101							
SS=E	Hazardous Areas	- Enclosure						
Bldg. 01	Hazardous Areas							
_		are protected by a fire						
		our fire resistance rating						
	_	rated doors) or an						
	l '	nguishing system in						
		3.7.1 or 19.3.5.9. When the						
approved automatic fire extinguishing system								
		e areas shall be separated						
		by smoke resisting						
	1	rs in accordance with 8.4.						
	Doors shall be sel							
		and permitted to have						
	_	applied protective plates that						
		inches from the bottom of						
	the door.	menee nem me bettern er						
		and zone locations of						
		that are deficient in						
	REMARKS.	inat are denoish in						
	19.3.2.1, 19.3.5.9							
	10.0.2.1, 10.0.0.0							
	Area	Automatic Sprinkler						
		N/A						
		-Fired Heater Rooms						
		er than 100 square feet)						
	, -	nance, and Paint Shops						
		ooms (exceeding 64						
	gallons)	( <del></del>						
	e. Trash Collection	n Rooms						
	(exceeding 64 gal							
		orage Rooms/Spaces						
	(over 50 square fe	•						
		classified as Severe						
	Hazard - see K32							
		ation and interview, the facility	K 0321		K321– It is the intent of the fa	cility	10/14/2022	
		rotection of 1 of 1 hot oil	18 0321		to ensure to maintain protection	-	10/11/2022	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIE			1000 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	popcorn popper in deficient practice of residents in the material findings include:  Based on observate Administrator and 09/29/22 between stationary hot oil printer in the Activities Armachine was used hot oil popcorn poperate. I of the 2 conformation Area and is open to the other time of observate acknowledged the stated they would propose machine with the finding was read Maintenance I and again during the such as storage root such as storage root are sident in the material finding was read again during the such as storage root as storage root are sident finding to the such as st	ion and interview with the Maintenance Director on 12:15 p.m. and 2:30 p.m., a large ropcorn popper was being used rea. When asked where the the Administrator stated the pper was used in the Activities rridor doors to the Activities a self-closing device installed corridor. Based on interview at ation, the Administrator aforementioned condition and protect the area where the		TAG	hot oil popcorn popper in the Activities area and to ensure hazardous area doors, such a storage rooms, are provided w properly working self closing devices to meet set standards 1. CORRECTIVE ACTION:  TAKEN:  a. On10/6/22 the Activity Director/ Maintenance Supervisor/designee will ensu when the hot oil popcorn poppen not in use, it will be stored in a room with a self closing devices the door to meet set standards. The Administrator verified the on10/6/22 the Maintenance Supervisor/designinstalled a self closing devices the corridor door to the Scheduler's office to meet set standards. The Administrator verified the work on10/6/22  c. On10/6/22 the Maintenance Supervisor/designinstalled a self closing devices the corridor door to the Scheduler's office to meet set standards. The Administrator verified the work on10/6/22	s vith . S re er is e on s. work unee	DATE
	deficient practice of	could affect more than 10 as staff and visitors.			MDS/Medical Records office to meet set standards. The	0	

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Findings include:

following was noted:

Based on observation and interview with the

Administrator and Maintenance Director on

09/29/22 between 12:15 p.m. and 2:30 p.m., the

A) The Schedulers Office, greater than 50 square

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\_\_10/6/22\_\_\_\_.

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Administrator verified the work on

**ALL OTHERS WITH** 

POTENTIAL TO BE AFFECTED:

and visitors have the potential to

be affected but none were. On \_10/6/22\_\_ the Maintenance Supervisor/designee inspected all

All residents and all staff

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	ETED
		155304	B. WING		09/29/	2022
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .		16TH ST		
WATERS	OF NEW CASTLE	, THE		ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	feet, contained a nu	mber of combustible items,		hazardous areas for self-closir	ng	
	such as, paper, plast	tic, and several "Cubex"		devices and found no other		
	cardboard boxes. T	he corridor door to this room		negative findings.		
	was not equipped w	rith a self-closing device.		2. MEASURES TO PREVE	ENT	
				REOCCURRENCE:		
	B) The MDS/Medic	cal Records office, greater than		a. On10/6/22 the		
	50 square feet, had	at least 10-12 large cardboard		Administrator inserviced the		
	boxes stored inside	the room. The room not		Maintenance		
	equipped with a self	f-closing device or self-closing		Supervisor/designee/Schedule	er/M	
	hinges.			DS,Medical Records Staff/All	Staff	
				on the requirement that all		
	The finding was rev	viewed with the Administrator		hazardous area doors must ha	ave	
	and Maintenance D	irector at the time of discovery		self-closing devices to meet se	et	
	and again during the	e exit conference at 3:00 p.m.		standards.		
				b. Maintenance		
	3.1-19(b)			Supervisor/designee will inspe	ect	
				all hazardous area doors		
				throughout the facility monthly	for	
				functioning self-closing device	s as	
				a part of the facility's Preventiv	ve	
				Maintenance Program and		
				document those inspection res	sults	
				as appropriate. If any issues	are	
				discovered, they will be addre		
				and resolved immediately. Th		
				Maintenance Supervisor/desig	gnee	
				will review with the Administra	tor	
				the inspection results.		
				c. The Administrator will		
				monitor adherence to the		
				Preventative Maintenance		
				schedule and validate the		
				Preventative Maintenance		
				documentation is in place.		
				3. MONITORING		
				CORRECTIVE ACTION:		
				a. The inspection results w	vill	
				be presented by the Maintena	nce	

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Supervisor/designee to the Administrator monthly and the

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  09/29/2022
	ROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP ( 16TH ST CASTLE, IN 47362	COD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II construction measure substituted for sprinklers where state sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and	Installation  Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler  Instruction, alternative hes are permitted to be inkler protection in specific for local regulations prohibit had a required in patient sleeping rooms the closet does not exceed sprinkler coverage covers that as required by NFPA 13,		Administrator will pressinspection results at the Quality Assurance/Pel Improvement (QA/PI) Inspection results and components will be rethe QA/PI Committee subsequent plans of codeveloped and implendeemed necessary to compliance is maintain. This plan of correction constitutes our crediction allegation of complianall regulatory require. Our date of complian—10/14/22—.  Requesting Paper Complianal Requesting Paper Complian Paper Complianal Paper	ne monthly rformance meeting. system viewed by with orrection nented as ensure ned. on ble nce with ments. ce is

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
155304 B. WING			09/29/2022		
	PROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Systems.  19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure the heads were not obstoof 8 corridors in acc 13, 2010 edition, Se shall be located so a discharge as defined additional sprinkler adequate coverage of and 8.5.5.3 do not prononcontinuous obstools inches below the horizontal plane mosprinkler deflector to from fully developing could up to 5 resides  Findings include:  Based on observation Administrator and Monople 12 orridor exit sign now was suspended from was located approximated approximated in the sign of the si	19.3.5.3, 19.3.5.4, 9.3.5.10, 9.7, 9.7.1.1(1) on and interview, the facility spray pattern for sprinkler ructed in 4 of 4 closets and 1 cordance with 19.3.5.1. NFPA ection 8.5.5.1 states sprinklers as to minimize obstructions to d in 8.5.5.2 and 8.5.5.3 or as shall be provided to ensure of the hazard. Sections 8.5.5.2 termit continuous or ructions less than or equal to a sprinkler deflector or in a fire than 18 inches below the hat prevent the spray patterning. This deficient practice ints.  On and interview with the Maintenance Director on 2:15 p.m. and 2:30 p.m., the car resident room 324 which in the ceiling in the corridor, simately 4-6 inches from a finkler head. The Administrator forementioned sprinkler head	K 0351	K351– It is the intent of the facility to ensure the spray part for sprinkler heads are not obstructed and are in accordated with 19.3.5.1 to meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. On10/6/22 the Maintenance Supervisor/design will relocate the exit sign near resident room 324 to meet set standards. The Administrator verified the work on10/6/2.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTION a. All residents and all state and visitors have the potential be affected but none were.  3. MEASURES TO PREVENCE:  a. On10/6/22 the Administrator inserviced the Maintenance Supervisor/design on the requirement to ensure spray pattern for sprinkler heads are not obstructed to meet set standards.  b. Maintenance Supervisor/designee will inspeciall sprinklers monthly to ensure the spray pattern for sprinkler heads are not obstructed as a of the facility's Preventive Maintenance Program and	tern nce  S gnee t 22 ED: ff to ENT gnee the dds t ect ee

document those inspection results

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/29/2022
	ROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE
K 0353	NFPA 101			as appropriate. If any issultiscovered, they will be add and resolved immediately. Maintenance Supervisor/de will review with the Administ the inspection results. c. The Administrator with monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection result be presented by the Maintenance Supervisor/designee to the Administrator monthly and Administrator will present the Inspection results at the monitor Quality Assurance/Perform Improvement (QA/PI) meet Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance is all regulatory requirement Our date of compliance is10/6/22 Requesting Paper Compliance.	dressed The esignee strator  II  Its will enance the ne onthly ance ing. eem ed by etion ed as are  with ts.
SS=F Bldg. 01	Sprinkler System	- Maintenance and Testing - Maintenance and Testing			

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155304		A. BUILDING B. WING	<u>01</u>	COMPLETED 09/29/2022	
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE			1000 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY:  (EACH DEFICIEN REGULATORY OR  Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAR coverage for any re automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on observate failed to ensure 1 of provided with spare cabinet and a sprink NFPA 25, Standard and Maintenance of Systems, 2011 Edit supply of spare sprinkler shall be maintained sprinklers that have any way can be pro- shall correspond to ratings of the sprink sprinklers shall be ke the temperature in very no time exceed 100 sprinkler wrench sh cabinet to be used in	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available. system last checked  system test  supply source  RKS information on non-required or partial r system.	NEW C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  K353 — It is the intent of the facility to ensure sprinkler systems are provided with sparsprinklers, a spare sprinkler cabinet and a sprinkler wrench the premises and to ensure sprinkler heads in the laundry are not loaded or covered with foreign material in accordance LSC 9.7.5 to meet set standar  1.CORRECTIVE ACTIONS TAKEN:  1.On10/7/22 a Licensed Sprinkler Contractor/Maintenance Supervisor/designee will install second cabinet to ensure all s	10/14/2022  Tre  The on the original area with the ds.
	all residents and sta	ff in the facility.		sprinkler heads are secured in their own protective slots and secured in holders to meet set	are

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 01			COMPLETED	
		155304	B. W	ING		09/29/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER				16TH ST	
WATERS	OF NEW CASTLE	, THE		NEW C	CASTLE, IN 47362	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	D 1 1 2	ar a sala			standards. The Administrator	
		on and interview with the			verified the work on10/7/2	<sup>22</sup>
		Maintenance Director on				
		2:15 p.m. and 2:30 p.m., there			2.On10/6/22 a	
		ler cabinets in the riser room			Licensed Sprinkler	
	_	sprinklers which were not in			Contractor/Maintenance	
	-	slots. They were stored loose			Supervisor/designee repaired	
		ot secured in holders. Based			sprinkler head in the laundry r	oom
		time of the observation, the			that was covered in dust or	
		ed the spare sprinkler cabinet			showed signs of loading to me	
		not in protected slots and			set standards. The Administra	
	stated another box v	vould be needed.			verified the work on _10/6/22_	_
	The finding was rev	riewed with the Administrator			2.ALL OTHERS WITH	
	and Maintenance D	irector at the time of discovery			POTENTIAL TO BE AFFECTE	ED:
	and again during the	e exit conference at 3:00 p.m.			1.All residents and all sta	aff
					and visitors have the potential	to
	2. Based on observa	ation and interview, the facility			be affected but none were.	
	failed to ensure 1 of	2 sprinkler heads in the			3.MEASURES TO PREVEN	т
	laundry area were n	ot loaded or covered with			REOCCURRENCE:	
	foreign material in a	accordance with LSC 9.7.5.			1.On10/6/22 the	e
	NFPA 25, 2011 edit	tion, at 5.2.1.1.1 sprinklers shall			Administrator inserviced the	
	not show signs of le	akage; shall be free of			Maintenance Supervisor/desig	gnee
	corrosion, foreign n	naterials, paint, and physical			on the requirement that the	
	damage; and shall b	e installed in the correct			sprinkler system must be prop	perly
	orientation (e.g., up	-right, pendent, or sidewall).			maintained to meet set standa	ards.
		1.1.2 any sprinkler that shows			2.Maintenance	
	signs of any of the f	following shall be replaced: (1)			Supervisor/designee will ensu	re
		ion (3) Physical Damage (4)			the sprinkler systems are prov	vided
		glass bulb heat responsive			with spare sprinkler heads	
	` ′	g (6) Painting unless painted by			secured in their own protective	e
	-	acturer. This deficient practice			slots and the sprinkler heads	are
	could affect 3 laund	ry staff.			not loaded or covered with for	eign
					material as a part of the facility	
	Findings include:				Preventive Maintenance Prog	ram
					and document those inspection	n
	Based on observation	on and interview with the			results as appropriate. If any	
	Administrator and N	Maintenance Director on			issues are discovered, they w	ill be
	09/29/22 between 1	2:15 p.m. and 2:30 p.m., 1 of 2			addressed and resolved	
	sprinkler heads in th	ne laundry room were coved in			immediately. The Maintenand	ce

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155304	B. WING		09/29/2022
	PROVIDER OR SUPPLIER		1000	r address, city, state, zip cod N 16TH ST CASTLE, IN 47362	
(VA) ID	CIDALADA	OTATEMENT OF DEPLOYED OF			(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	and Maintenance D	viewed with the Administrator birector at the time of discovery e exit conference at 3:00 p.m.		Supervisor/designee will reviewith the Administrator the inspection results.  3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. MONITORING CORRECT ACTION:  1. The inspection results be presented by the Maintenance Supervisor/designee to 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.	will ance hly ce g. h by
				This plan of correction	
				constitutes our credible	
				allegation of compliance wit	h
				all regulatory requirements.	
				Our date of compliance is10/14/22	
				Requesting Paper Complian	се
K 0363	NFPA 101				
SS=E	Corridor - Doors				
Bldg. 01	Corridor - Doors				
		corridor openings in other			

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than required enclosures of vertical openings,

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION  01	(X3) DATE : COMPL 09/29/	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE			1	000 N	DDRESS, CITY, STATE, ZIP COD 16TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller I CMS regulation. The apply to auxiliary and apply to auxiliary and apply to auxiliary and and apply to auxiliary apply to aux	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are led protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,	K 036	3	K363 – It is the intent of the		10/14/2022
		f over 30 corridor doors had no	K 036.	)	facility to ensure corridor doors	S	10/14/2022

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Event ID:

H03O21 Facility ID: 000201

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/29/2022
	OF PROVIDER OR SUPPLIEF		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF impediment to clos frame and would re This deficient pract and staff.  Findings include:  Based on observation Administrator and 1 09/29/22 between 1 corridor doors to th near resident room 358, failed to close door frame. Based of	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ing and latching into the door sist the passage of smoke. ice could affect 10 residents  on and interview with the Maintenance Director on 2:15 p.m. and 2:30 p.m., the (1) e Therapy area double doors, 314 and (2) resident room # and latch positively into the on interview at the time of the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  have no impediment to closing latching into the door frame all would resist the passage of smoke to meet set standards.  1. CORRECTIVE ACTION TAKEN: a. On10/7/22 the Maintenance Supervisor/desig repaired the latching mechani on the A) corridor door to the Therapy area double doors, n resident room 314 and B) resi room 358 so the door fully clo and latches into the door frame	g and nd  S  gnee sms ear ident ses
	aforementioned cor and resident room of into the door frame passage of smoke.  The finding was revand Maintenance D	dministrator agreed the ridor therapy double doors door did not close and latch and would not resist the viewed with the Administrator firector at the time of discovery e exit conference at 3:00 p.m.		meet set standards. The Administrator verified the work10/7/22  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTION a. All residents and all stand visitors have the potential be affected but none were. The Maintenance Supervisor/designing latching mechanisms a found no other negative finding.  3. MEASURES TO PREVIOUS REOCCURRENCE:  a. On10/7/22 the Administrator inserviced the Maintenance Supervisor/designand all staff on the requirement that corridor doors may not have impediments to closing and the latching mechanism latches in the frame to meet set standard b. Maintenance Supervisor/designee will inspeciall corridor doors throughout the facility monthly to ensure the	ED:  ff I to he gnee r nd gs. ENT  gnee nt ave he he he ht ds. ect

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	F OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	
155304			B. WING	01	09/29/	
		100004			03/23/	2022
NAME OF I	PROVIDER OR SUPPLIEI	8		ADDRESS, CITY, STATE, ZIP COD		
				I 16TH ST		
WATERS	S OF NEW CASTLE	E, THE	NEW C	CASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	16	DATE
				latching mechanisms work		
				properly, impediments to closi	ng	
				are not in place, and the doors	-	
				have no holes which would all		
				the passage of smoke as a pa	rt of	
				the facility's Preventive		
				Maintenance Program and		
				document those inspection res	sults	
				as appropriate. If any issues	are	
discover		discovered, they will be addressed				
				and resolved immediately. Th	е	
				Maintenance Supervisor/design	jnee	
				will review with the Administra	tor	
				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 w		
				be presented by the Maintena	nce	
				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 I	ру	
				the QA/PI Committee with		
				subsequent plans of correction		
				developed and implemented a	IS	

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deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with

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			I KINTED.
PARTMENT OF HEALTH AND HUN	MAN SERVICES		FORM APPROVED
NTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION CONST	X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIEI		1000 1	ADDRESS, CITY, STATE, ZIP COD N 16TH ST 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				all regulatory requirements.  Our date of compliance is10/14/22  Requesting Paper Compliance	9
K 0712 SS=C Bldg. 01	alarm signal and so conditions. Fire drand unexpected to conditions, at least The staff is familia aware that drills a routine. Where draware that drills and should be alarms. 19.7.1.4 through a Based on record refailed to conduct find orientation training states drills shall be shift to familiarize interns, maintenance administrative staff emergency action reconditions. QSO-2 states in lieu of a plorientation training fire plan, which conconditions, is accept employees, including employees, on their procedures and the	19.7.1.7 view and interview, the facility re drills or documented on 2 of 4 quarters. LSC 19.7.1.6 e conducted quarterly on each facility personnel (nurses,	K 0712	K712 – It is the intent of the facility to ensure to conduct quarterly fire drills on each shift under varied conditions to meet set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On10/7/22 the Administrator inserviced the Maintenance Supervisor/design on the requirement that fire drill must be conducted at unexpect times under varying conditions least quarterly on each shift and documented to meet set standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED a. All residents and all staff	nee s ded at d

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155304		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/29/2022					
	PROVIDER OR SUPPLIER		1000 N	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE				
IAU	Findings include:  Based on record revand Maintenance D 10:15 a.m. and 12:1 missing documenta documented orienta a) 2nd and 3rd shift 2021. b) 3rd shift in the th Based on interview the administrator ag fire drills and staff safety procedures for quarters.  The finding was revand Maintenance D	view with the Administrator irrector on 09/29/22 between 5 p.m., the following shifts were tion of a completed fire drill or	IAG	and visitors have the potential be affected but none were.  3. MEASURES TO PREVINCE: a. Maintenance Supervisor/designee will ensifire drills are conducted at unexpected times under vary conditions at least quarterly ceach shift and documented of Fire Drill Report and that documentation be retained in facility's Life Safety Binder as part of the facility's Preventiv Maintenance Program and document those inspection reas appropriate. If any issued discovered, they will be addrand resolved immediately. The Maintenance Supervisor/designer 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 inspection results be presented by the Mainten Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performal Improvement (QA/PI) meetin Inspection results and syster components will be reviewed components will be reviewed.	rent ure ring on on the sa a see sessed she signee sator  will sance set thly noce g. n				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/29/2022			
NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE		1000 N	STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5)  LD BE COMPLETION  OPRIATE DATE			
				the QA/PI Committee with subsequent plans of corredeveloped and implement deemed necessary to enscompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requireme. Our date of compliance10/14/22  Requesting Paper Comp	ection ted as sure  with nts.			
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are re- completion of the installed and mee	ent - Power Cords and ent - Power Cords and ent - Power Cords and patient care vicinity are only ints of movable defectrical equipment des that have been diffied personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE ould 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed fixe. Extension cords used moved immediately upon purpose for which it was set the conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155304		B. WING			09/29/2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			1000 N 16TH ST				
WATERS OF NEW CASTLE, THE			NEW CASTLE, IN 47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	` '	(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 0	K 0920 K920 – It is the intent of the		10/14/2022	
		f 1 power strips were not used			facility to ensure power strips		
		ixed wiring to provide power			not used as a substitute for fix		
	equipment with a hi	_			wiring to provide power equip		
		0.8 state unless specifically			with a high current draw to me	eet	
	_	flexible cords and cables shall			set standards.		
		as a substitute for fixed wiring.			1.CORRECTIVE ACTIONS		
	•	ice could affect up to 2			TAKEN:		
	residents and 2 staff	f in the Social Services Office.			1.On10/6/22 the		
	F' 1' ' 1 1				Maintenance Supervisor/design	-	
	Findings include:				removed the power strip that		
	D1	1 :			being used to power a microw		
		on and interview with the			oven in the Social services off	rice	
	Administrator and Maintenance Director on				to meet set standards. The	1	
	09/29/22 between 12:15 p.m. and 2:30 p.m., in the				Administrator verified the rem	ovai	
	Social Services office a power strip was being				on10/6/22		
	used to power a microwave oven (high power				2.ALL OTHERS WITH	ED.	
	draw equipment).				POTENTIAL TO BE AFFECTI  1.All residents and all sta		
	The finding was rev	viewed with the Administrator					
	_	irector at the time of discovery			and visitors have the potential		
		e exit conference at 3:00 p.m.			be affected but none were. O		
	and again during th	e exit conference at 3.00 p.m.			10/6/22 the Maintenan Supervisor/designee inspecte		
	3.1-19(b)				rooms throughout the facility f		
	3.1-17(0)				power strips and found no oth		
					negative findings.		
					3.MEASURES TO PREVEN	т	
					REOCCURRENCE:		
					1.On10/6/22 the		
					Administrator inserviced the		
					Maintenance		
					Supervisor/designee/all staff t	hat	
					power strips are not to be use		
					a substitute for fixed wiring to		
					meet set standards.		
					2.Maintenance		
					Supervisor/designee will inspe	ect	
					all rooms throughout the facili		
				monthly to ensure they do not	-		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155304		A. BUILDING B. WING	01	COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIER		1000 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				have power strips in use as a of the facility's Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results.  3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4.MONITORING CORRECT ACTION:  1. The inspection results to be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month 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 with all regulatory requirements. Our date of compliance is10/14/22 Requesting paper compliance.	sults are ssed he gnee stor

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155304	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIEF		1000 N	ADDRESS, CITY, STATE, ZIP COD I 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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	
K 0927 SS=F Bldg. 01	Gas Equipment - Transfilling of oxy, another is in acco Transfilling of High Oxygen Used for any gas from one prohibited in patie to liquid oxygen or containers over 50 under 11.5.2.3.1 (liquid oxygen containers under conditions under 11.5.2.2 (NFPA 98 Based on observation failed to ensure 1 or rooms was provided transferring is occu states, the area is post that trans-filling is of the immediate area practice affects all in Findings include:  Based on observation Administrator and 1 09/29/22 between 1 oxygen storage/transhave access, did no indicating when transhis location. A mag door indicating transho distinction was	on and interview, the facility of 1 oxygen storage/transfer of with a sign indicating that rring. NFPA 99 11.5.2.3.1(3) osted with signs indicating occurring and that smoking in is not permitted. This deficient residents.  on and interview with the Maintenance Director on 2:15 p.m. and 2:30 p.m., the asfer room where all residents t have a posted sign asferring of oxygen occurs in gnetic sign was affixed to the asfilling was always occurring. made between when	K 0927	K927– It is the intent of the facto ensure oxygen storage/transrooms are provided with a sign indicating that transferring is occurring to meet set standard 1.CORRECTIVE ACTIONS TAKEN:  a. On10/7/22 the Administrator/DON/designee installed an informational sign stating staff should knock on d to ensure oxygen transfilling is in progress before opening the door on the oxygen storage/transfer room to meet standards. The Administrator verified the work on10/7/22 .  1.ALL OTHERS WITH POTENTAL TO BE AFFECTE	sfer n ds. door s not e set	
	No distinction was					

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Based on interview at the time of observation, the

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and visitors have the potential to

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155304		A. BUILDING <u>01</u>		(X3) DATE SURVEY  COMPLETED  09/29/2022				
	PROVIDER OR SUPPLIER		1000 I	STREET ADDRESS, CITY, STATE, ZIP COD 1000 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE			
	when trans-filling o transfilling was not This finding was ac Maintenance Direct	knowledged by the or and Field Maintenance ne of observation and again at		be affected but none were.  2.MEASURES TO PREVEREOCCURRENCE: a. On10/7/22 the DON/designee will monitor sign shows when transferrir occurring and ensure all nustaff is meeting set requirer per our Oxygen Policy & Procedures to meet set standards. b. The DON/designee will nadherence to the oxygen transfilling procedures per coxygen Policy and Procedure. The Administrator will madherence to the Oxygen Procedure and validate the Preventative Maintenance documentation is in place.  1.MONITORING CORRECT ACTION:  1.The inspection result be presented by the Mainte Supervisor/designee/DON/de to the Administrator will prese inspection results at the moduality Assurance/Performations in the Administrator will prese inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensurcompliance is maintained. This plan of correction constitutes our credible allocation of compliance is a suppliance of compliance is allocation of comp	the ng is raing nents  nonitor our tres. onitor olicy &  CTIVE  ts will nance designe hly and nt the nthly ance ng. em ed by tion d as re			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	01	COMPLETED		
155304		B. WING			09/29/2022		
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	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
					all regulatory requirements. Our date of compliance is10/14/22 Requesting paper complianc	e	

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