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	09/29/2022

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: 09/29/22 Facility Number: 000201 Provider Number: 155304 AIM Number: 100266780 At this Emergency Preparedness survey, The Waters of New Castle was found in substantial 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 53. Quality Review completed on 10/03/22	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We are requesting paper compliance.**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain a complete emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 09/29/22 between 10:15 a.m. and 12:15 p.m., the provided EPP did not include current contact information for all facility staff, in both the EPP maintained by the Administrator and in the EPP kept at the nurse's station. The EPP from the nurses station contained contact information for a previous administrator as well as other facility personnel. Based on an interview during records review, the Administrator agreed that contact information in the two provided EPP plans did not match and was not current. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m.	E 0029	**E029**– It is the intent of the facility to ensure to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws which is reviewed and updated at least annually in accordance with 42 CFR 483.73 (a) to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 10/5/22 the Administrator and the Maintenance Supervisor/designee reviewed and updated the facility's Emergency Preparedness Policy Manual at the nurses station as appropriate including current contact information for all facility staff to meet set standards. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. The facility has only one Emergency Preparedness Policy Manual. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On _ 10/5/22__ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the facility's Emergency Preparedness Policy Manual must be reviewed at least annually and	10/14/2022

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			updated as frequently as necessary with documentation noting the reviews and changes on the Reviews and Revisions (page 5) to meet set standards. b) On _ 10/5/22__ the Administrator and the Maintenance Supervisor/designee inserviced all staff on the updated Emergency Preparedness Policy Manual and obtained signed copies of the Emergency Preparedness Policy Manual Certification Sheet to be filed in each employee's personnel file to 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 ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as 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 Compliance**	

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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: 09/29/22 Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910 At this Life Safety Code survey, The Waters of 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 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 53 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 10/03/22	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. We are requesting paper compliance.**	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 5 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: 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 following was noted: a) during the initial walk through of the facility prior to the entrance conference, more than 8 wheelchairs were being stored in the corridor between resident rooms 362 and 378. The aforementioned wheelchairs had been relocated later in the day before the facility tour. b. near stairwell number 3, a rope type strap barrier was being used to restrict access to the facility exit. During interview at the time of discovery, the Administrator stated that the barrier was in place to discourage elopement. Based on interview at the time of the observations, the Administrator agreed the aforementioned means of egresses were not continuously maintained free of all obstructions	K 0211	**K211** – It is the intent of the facility to ensure to provide means of egress continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ___10/5/22____ the Maintenance Supervisor/designee 1. removed the wheelchairs that were being stored in the corridor between resident room 362 & 378 and 2. Removed the rope type strap barrier near stairwell number 3 to meet set standards. The Administrator verified the removals on _10/5/22__ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On ____10/6/22_____ the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings.	10/14/2022

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	or impediments to full instant use in the case of fire or other emergency. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)		3. **MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/5/22____ the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING 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.	

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			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 _10/14/22___.** **Requesting Paper Compliance**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 administrators office door was provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 6 occupants in the office area. Findings include: 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 Administrators Office/Conference room corridor door was equipped with two latching devices, a regular door handle with a turn latching mechanism and a separate keyed claw type locking latch. The Administrator agreed that, when locked, to exit the Administrators Office/Conference Room it would require two separate actions to open the door. This finding was acknowledged by the Maintenance Director and Field Maintenance Supervisor at the time of observation and again at the Exit Conference at 4:15 p.m. 3.1-19(b)	K 0222	**K222**– It is the intent of the facility to ensure administrator's office door is provided with only one latching mechanism to release the door and open to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ___10/6/22_____ the Maintenance Supervisor/designee removed the second locking mechanism from the administrators office/conference room corridor door so door will only have one locking mechanism to meet set standards. The Administrator verified the work on ___10/6/22__ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On __10/6/22__ the Maintenance Supervisor/designee inspected all doors to ensure it is provided with only one latching mechanism and found no other negative findings. 2. **MEASURES TO PREVENT REOCCURRENCE**: a. On _10/6/22__ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that doors must only have one latching mechanism to meet set standards. b. Maintenance Supervisor/designee will inspect	10/14/2022

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			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. 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 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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			___10/14/22____. **Requesting Paper Compliance**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil	K 0321	**K321**– It is the intent of the facility to ensure to maintain protection of	10/14/2022

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	popcorn popper in the Activities area. This deficient practice could affect staff and up to 35 residents in the main activities area. Findings include: 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., a large stationary hot oil popcorn popper was being used in the Activities Area. When asked where the machine was used the Administrator stated the hot oil popcorn popper was used in the Activities Area. 1 of the 2 corridor doors to the Activities Area did not have a self-closing device installed and is open to the corridor. Based on interview at the time of observation, the Administrator acknowledged the aforementioned condition and stated they would protect the area where the popcorn machine will be used. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: 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 following was noted: A) The Schedulers Office, greater than 50 square		hot oil popcorn popper in the Activities area and to ensure hazardous area doors, such as storage rooms, are provided with properly working self closing devices to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On __10/6/22____ the Activity Director/ Maintenance Supervisor/designee will ensure when the hot oil popcorn popper is not in use, it will be stored in a room with a self closing device on the door to meet set standards. The Administrator verified the work on __10/6/22_ . b. On _10/6/22____ the Maintenance Supervisor/designee installed a self closing device to the corridor door to the Scheduler's office to meet set standards. The Administrator verified the work on __10/6/22___ . c. On __10/6/22__ the Maintenance Supervisor/designee installed a self closing device to the corridor door to the MDS/Medical Records office to meet set standards. The Administrator verified the work on __10/6/22____ . **1. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On __10/6/22__ the Maintenance Supervisor/designee inspected all	

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	feet, contained a number of combustible items, such as, paper, plastic, and several "Cubex" cardboard boxes. The corridor door to this room was not equipped with a self-closing device. B) The MDS/Medical Records office, greater than 50 square feet, had at least 10-12 large cardboard boxes stored inside the room. The room not equipped with a self-closing device or self-closing hinges. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)		hazardous areas for self-closing devices and found no other negative findings. **2. MEASURES TO PREVENT REOCCURRENCE**: a. On __10/6/22__ the Administrator inserviced the Maintenance Supervisor/designee/Scheduler/MDS,Medical Records Staff/All Staff on the requirement that all hazardous area doors must have self-closing devices to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly for functioning self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. BUILDING 01 B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN 47362

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			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 __10/14/22__.** Requesting Paper Compliance	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 4 of 4 closets and 1 of 8 corridors in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could up to 5 residents. Findings include: 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 corridor exit sign near resident room 324 which was suspended from the ceiling in the corridor, was located approximately 4-6 inches from a ceiling mounted sprinkler head. The Administrator acknowledged the aforementioned sprinkler head was obstructed by the exit sign . The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)	K 0351	**K351**– It is the intent of the facility to ensure the spray pattern for sprinkler heads are not obstructed and are in accordance with 19.3.5.1 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On __10/6/22____ the Maintenance Supervisor/designee will relocate the exit sign near resident room 324 to meet set standards. The Administrator verified the work on ___10/6/22___ . **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 ___10/6/22____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the spray pattern for sprinkler heads are not obstructed to meet set standards. b. Maintenance Supervisor/designee will inspect all sprinklers monthly to ensure the spray pattern for sprinkler heads are not obstructed as a part of the facility's Preventive Maintenance Program and document those inspection results	10/14/2022

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			as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING 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 ___10/6/22__.** **Requesting Paper Compliance**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include:	K 0353	**K353** – It is the intent of the facility to ensure sprinkler systems are provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises and to ensure sprinkler heads in the laundry area are not loaded or covered with foreign material in accordance with LSC 9.7.5 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On __10/7/22___ a Licensed Sprinkler Contractor/Maintenance Supervisor/designee will install a second cabinet to ensure all spare sprinkler heads are secured in their own protective slots and are secured in holders to meet set	10/14/2022

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	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., there were 2 spare sprinkler cabinets in the riser room that included spare sprinklers which were not in their own protected slots. They were stored loose in the cabinet and not secured in holders. Based on interview at the time of the observation, the Administrator agreed the spare sprinkler cabinet had spare sprinklers not in protected slots and stated another box would be needed. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 laundry staff. Findings include: 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., 1 of 2 sprinkler heads in the laundry room were coved in		standards. The Administrator verified the work on ___10/7/22__ . 2.On __10/6/22__ a Licensed Sprinkler Contractor/Maintenance Supervisor/designee repaired the sprinkler head in the laundry room that was covered in dust or showed signs of loading to meet set standards. The Administrator verified the work on _10/6/22__ . **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 ___10/6/22____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are provided with spare sprinkler heads secured in their own protective slots and the sprinkler heads are not loaded or covered with foreign material 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	

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	dust or showed signs of loading. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)		Supervisor/designee will review with 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 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 ___10/14/22___.** **Requesting Paper Compliance**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no	K 0363	**K363** – It is the intent of the facility to ensure corridor doors	10/14/2022

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	impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 10 residents and staff. Findings include: 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 (1) corridor doors to the Therapy area double doors, near resident room 314 and (2) resident room # 358, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Administrator agreed the aforementioned corridor therapy double doors and resident room door did not close and latch into the door frame and would not resist the passage of smoke. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)		have no impediment to closing and latching into the door frame and would resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On __10/7/22___ the Maintenance Supervisor/designee repaired the latching mechanisms on the A) corridor door to the Therapy area double doors, near resident room 314 and B) resident room 358 so the door fully closes and latches into the door frame to meet set standards. The Administrator verified the work on __10/7/22___ . **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. The Maintenance Supervisor/designee inspected all corridor doors for failing latching mechanisms and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On __10/7/22__ the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors may not have impediments to closing and the latching mechanism latches into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure the	

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			latching mechanisms work properly, impediments to closing are not in place, and the doors have no holes which would allow the passage of smoke as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING 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**	

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			all regulatory requirements. Our date of compliance is __10/14/22__. Requesting Paper Compliance	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients.	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. On __10/7/22__ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at 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	10/14/2022

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	Findings include: Based on record review with the Administrator and Maintenance Director on 09/29/22 between 10:15 a.m. and 12:15 p.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) 2nd and 3rd shift during the fourth quarter of 2021. b) 3rd shift in the third quarter of 2022. Based on interview at the time of record review, the administrator agreed there were three missing fire drills and staff has not been trained in the fire safety procedures for the third and fourth quarters. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b) 3.1-51(c)		and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder 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. 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 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	

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			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 ___10/14/22___.** **Requesting Paper Compliance**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8			

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	155304	A. BUILDING 01 B. WING	09/29/2022

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
	(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the Social Services Office. Findings include: 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., in the Social Services office a power strip was being used to power a microwave oven (high power draw equipment). The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:00 p.m. 3.1-19(b)	K 0920	**K920** – It is the intent of the facility to ensure power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On __10/6/22___ the Maintenance Supervisor/designee removed the power strip that was being used to power a microwave oven in the Social services office to meet set standards. The Administrator verified the removal on __10/6/22___ . **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. On __10/6/22____ the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On __10/6/22__ the Administrator inserviced the Maintenance Supervisor/designee/all staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not	10/14/2022

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			have power strips in use 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. 3.The Administrator will monitor adherence to the Preventative Maintenance 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 __10/14/22__.** **Requesting paper compliance**	

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K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice affects all residents. Findings include: 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 oxygen storage/transfer room where all residents have access, did not have a posted sign indicating when transferring of oxygen occurs in this location. A magnetic sign was affixed to the door indicating transfilling was always occurring. No distinction was made between when transfilling was occurring and when it was not. Based on interview at the time of observation, the	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage/transfer rooms are provided with a sign indicating that transferring is occurring to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On __10/7/22___ the Adminstrator/DON/designee installed an informational sign stating staff should knock on door to ensure oxygen transfilling is not in progress before opening the door on the oxygen storage/transfer room to meet set standards. The Administrator verified the work on __10/7/22___ . **1.ALL OTHERS WITH POTENTAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to	10/14/2022

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	Administrator stated there was not a sign stating when trans-filling oxygen is occurring and when transfilling was not occuring. This finding was acknowledged by the Maintenance Director and Field Maintenance Supervisor at the time of observation and again at the Exit Conference at 4:15 p.m. 3.1-19(b)		be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/7/22____ the DON/designee will monitor the sign shows when transferring is occurring and ensure all nursing staff is meeting set requirements per our Oxygen Policy & Procedures to meet set standards. b. The DON/designee will monitor adherence to the oxygen transfilling procedures per our Oxygen Policy and Procedures. c. The Administrator will monitor adherence to the Oxygen Policy & Procedure and validate the Preventative Maintenance documentation is in place. **1.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee/DON/designe e 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**	

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			all regulatory requirements. Our date of compliance is ___10/14/22___. Requesting paper compliance	