STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155581	A. BUILDING -- B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/18/23 Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450 At this Emergency Preparedness survey, The Waters of Syracuse Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 66 certified beds. Sixty beds are dually certified for Medicare and Medicaid. Six beds are certified for Medicare only. At the time of the survey, the census was 33. Quality Review completed on 01/23/23	E 0000	The Waters of Syracuse, Syracuse Indiana does hereby request consideration for Paper Compliance for the Plan of Completion submitted for our annual survey dated January 18,2023. Attached with our plan of correction, which we believe responds to corrections and system implementation are documents that address education and audit materials used in attaining and maintaining substantial compliance with the findings. If you should need any further documentation or information, please do not hesitate to contact the facility Administration at 574-457-4401 or through the Gateways system e-mail. Thank you, Carolyn Davidson, HFA	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/18/23 Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450	K 0000	The Waters of Syracuse, Syracuse Indiana does hereby request consideration for Paper Compliance for the Plan of Completion submitted for our annual survey dated January 18,2023. Attached with our plan of correction, which we believe responds to corrections and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carolyn Davidson	Administrator	02/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	At this Life Safety Code survey, The Waters of Syracuse Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, the 2010 edition of the National Fire Protection Association (NFPA) 99 Health Care Facilities Code and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has 66 certified beds. Sixty beds are dually certified for Medicare and Medicaid. Six beds are certified for Medicare only. At the time of the survey, the census was 33. All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance equipment, shed, and enclosed generator house. Quality Review completed on 01/23/23		system implementation are documents that address education and audit materials used in attaining and maintaining substantial compliance with the findings. If you should need any further documentation or information, please do not hesitate to contact the facility Administration at 574-457-4401 or through the Gateways system e-mail. Thank you, Carolyn Davidson, HFA	
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			

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	through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 3 resident hall exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could 15 residents in one hall. Findings include: Based on observations with the Maintenance Director on 01/18/23 at 12:13 p.m., resident hall exit door #7 was equipped with panic hardware, but the door would not open on the first try. It took the Maintenance Director three tries to open the door and took excessive force to open the door on the fourth try. Based on interview at the time of observation, the Maintenance Director agreed it took excessive force to open the exit door. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	**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.** **K211** – It is the intent of the facility to ensure to maintain resident hall exit discharges doors are free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/30/23 the Maintenance Supervisor/designee repaired the resident hall exit door #7 to meet set standards. The Administrator verified the repair on 2/2/23 (Exhibit #1). 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff	02/03/2023

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			and visitors have the potential to be affected but none were. On the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 2/1/23 the Administrator in-serviced the Maintenance Supervisor/designee and all other staff on the requirement to maintain resident hall exit doors are free of impediments to full instant use in the case of fire or other emergency to meet set standards (Exhibit #2 all staff in-service). b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly 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	

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			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 2/3/23.**	
K 0222 SS=F 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.			

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	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 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			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 resident hall exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice affects all residents. Findings include: Based on observation with the Maintenance Director on 01/18/23 Between 11:30 a.m. and 12:30 p.m., the exit doors in all 3 resident halls were marked as facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pads, but the codes were not posted at the exits. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit doors were not posted by the access control pads. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	**K222 -** It is the intent of the facility to ensure means of egress through resident hall exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 1/30/23 the Maintenance Supervisor/designee posted the information on how to obtain the code at the exit doors in all 3 resident halls marked as facility exits to meet set standards. The Administrator verified the posting of the codes on 1/31/23 (Exhibit #3). 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 1/30/23 the Maintenance Supervisor/designee inspected all doors to the means of egress to ensure they were readily accessible for use and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 1/31/23 the Administrator in-serviced the Maintenance Supervisor/designee	02/03/2023

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			and all staff on the requirement that doors must be readily accessible for use to meet set standards. The codes 4401 are posted at the end of the halls for exit #4, #7, #3 is in a simple math problem (Exhibit #3). b. Maintenance Supervisor/designee will inspect all means of egress throughout the facility weekly to ensure doors are readily accessible for 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. 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	

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			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 2/3/23.**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation, record review, and interview the facility failed to ensure the 34 of 34 battery operated smoke alarms in resident rooms were replaced according to manufacturer's published instructions. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient	K 0300	**K300**– It is the intent of the facility to ensure battery operated smoke alarms in resident rooms are replaced according to manufacturer's published instructions to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 1/30/23 the Maintenance Supervisor/designee replaced the battery-operated smoke detectors and batteries in resident rooms that had a date of 11/30/2011 to meet set standards. The Administrator verified the work on 1/31/23 (Exhibit #4). **2) ALL OTHERS WITH**	02/03/2023

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	practice could affect all residents. Findings include: Based on observation with the Maintenance Director and Administrator on 01/18/23 at 10:30 a.m., the battery-operated smoke alarms installed in resident rooms had a date of 11/30/2011 written on the back of the smoke alarms. Based on records review at 10:22 a.m., the battery-operated smoke alarm manufacturer's published instructions stated, "You should replace a smoke alarm after 10 years from date of purchase." Based on interview at the time of records review and observation, the Maintenance Director and Administrator agreed the smoke alarms were older than 10 years and needed to be replaced. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 1/31/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that battery operated smoke alarms must be maintained per manufacture's guidelines and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will replace the battery-operated smoke detectors after 10 years of purchase and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the 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	

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			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 2/3/23.**	
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			

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	(outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 3 of 3 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 15 residents in front office area and in the Activities room. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 01/18/23 Between 11:00 a.m. and 12:30 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Social Services office and the Activities room. Also, a toaster (high power draw equipment) was plugged into and supplied power by a power strip in the Break room. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment. The finding was reviewed with the Administrator and Maintenance Director during the exit	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 1/27/23 the Maintenance Supervisor/designee removed the power strips from the Social Services office and the Activities Room and the break room to meet set standards. The Administrator verified the removal on 1/31/23 (Exhibit #5.1 and 5.2). **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 1/30/23 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**:	02/03/2023

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WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

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	conference. 3.1-19(b)		1.On 2/1/23 the Administrator in-serviced the Maintenance Supervisor/designee/all other 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. BUILDING 01 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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 2/3/23.**	