STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155217	B. WING		10/15/2024	
			OWNERS	ADDRESS SITE STATE SIR COR		
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD ELAND DR		
WATED		BC THE		NGBURG, IN 47542		
WATERS	S OF HUNTINGBU	KG, THE	HUNTI	NGBURG, IN 47542		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY 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	
E 0000						
Bldg						
		eparedness Survey was	E 0000	Preparation and/or execution		
	1	ndiana Department of Health in		this plan of correction in gene		
	accordance with 42	2 CFR 483.73.		or this corrective action, does	not	
				constitute an admission or		
	Survey Date: 10/1	5/24		agreement by this facility of the		
	n 71. 37. 1	000122		facts alleged or conclusions s	et	
	Facility Number: (forth in this statement of		
	Provider Number:			deficiencies. The plan of	.	
	AIM Number: 100290560			correction and specific correc	tive	
	Avd' E B 1 TI			actions are prepared and/or		
		Preparedness survey, The		executed in compliance with		
	Waters of Huntingburg was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid			and federal laws. This plan o		
				correction constitutes a writte	n	
	_			allegation of substantial	:	
		ders and Suppliers, 42 CFR		compliance with Federal Med	icare	
	483.73.			and Medicaid requirements.		
	The facility has 05	certified beds. At the time of				
	the survey, the cen					
	the survey, the cen	sus was 11.				
	Ouality Review co	mpleted on 10/16/24				
	Quality Iteview ee	impleted on 10/10/21				
	The requirement at	t 42 CFR, Subpart 483.73 is NOT				
	MET as evidenced					
		,				
E 0041	482.15(e), 483.73	3(e), 485.542(e), 485.62				
SS=F	Hospital CAH and	d LTC Emergency Power				
Bldg						
	Based on record re	view and interview, the facility	E 0041	E041- It is the intent of the fa	acility 10/28/2024	
		t the emergency power system		to ensure emergency general	or is	
	inspection, testing,	and maintenance requirements		provided with an alarm annur	ciator	
	found in the Health	n Care Facilities Code, NFPA		in a location readily observed	by	
		ty Code in accordance with 42		operating personnel at a regu	lar	
	CFR 483.73(e)(2).			work station such as nurses'		
				station and to maintain a		
		vation and interview, the		complete written record of mo	onthly	
	facility failed to en	sure 1 of 1 emergency generator		generator load testing for		
	<u> </u>			l		
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Rebecca E	Brown		ADM, H	FA	10/29/2024	

Rebecca Brown

ADM, HFA

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

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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PRINTED: 11/04/2024

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155217	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIER			1712 L	address, city, state, zip cod ELAND DR NGBURG, IN 47542		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR was provided with a location readily obs	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION an alarm annunciator in a erved by operating personnel ation such as a nurses'		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) generator during all 12 mont the year to meet set standard CORRECTIVE ACTION	hs of ds.	(X5) COMPLETION DATE
	stations. NFPA 99, Facilities Code, at 6 annunciator that is s be provided to oper room in a location r personnel at a regul annunciator shall be	2012 Edition, Health Care 6.4.1.1.17 requires a remote storage battery powered shall atte outside of the generating eadily observed by operating ar work station. The e hard-wired to indicate alarm nergency or auxiliary power			TAKEN: a On 10/28/2024 the fact licensed generator contractor relocated the alarm annunciathe occupied unit 1 nurses's to meet set standards. The Administrator verified the wor 10/28/2024. b On 10/23/2024 the	ilities r ator to tation	
	(1) Individual visua a. When the emerg is operating to supp b. When the battery (2) Individual visua audible signal to wa alarm condition sha a. Low lubricating	y charger is malfunctioning. al signals plus a common urn of an engine-generator Il indicate: oil pressure.			Maintenance Supervisor conducted the monthly load testing of the generator and documented the results in th facilities life safety binder to set standards. The Administrator verified the wo 10/28/24	meet	
	contains less than a e. Overcrank (faile f. Overspeed. Where a regular wo periodically, an aud signal, appropriatel at a continuously m derangement signal	temperature. he main fuel storage tank 4-hour operating supply.			2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all sta and visitors have the potentia be affected but none were. 3 MEASURES TO PREV REOCCURRENCE: a On 10/28/2024 the Administrator inserviced the Maintenance Supervisor/des on the requirement to ensure	aff all to ENT ignee the	
	not display these co	nditions individually. This ould affect all residents, as well			generator alarm annunciator located in a location readily observed by operating perso and to ensure monthly generating personal to ensure monthly generating personal to ensure monthly generating personal description.	nnel	

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Findings include:

Based on observation on 10/15/24 between 11:30

a.m. and 2:00 p.m. during a tour of the facility with

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load testing is being completed

/designee will ensure the

and documented in the life safety binder to meet set standards.

The Maintenance Supervisor

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155217		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIER		1712 L	ADDRESS, CITY, STATE, ZIP COD ELAND DR NGBURG, IN 47542	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and Administrator-in-Training	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) generator alarm annunciator i	DATE
	(AIT), the remote generator annunciator panel was located at the Unit 2 Nurse's Station which was not currently in operation. When asked, the Administrator said Unit 2 is currently closed due to a low census. There are no residents currently			located in a location readily observed by operating persor and will ensure monthly gene load testing is being complete and documented in the facilities.	nnel rator d
	located on the Mem long corridor and or smoke barrier doors panel would not be	earest Nurse's Station is ory Care, which was down a in the other side of a set of it. The generator annunciator heard or seen from the		life safety binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Po	licy
	This finding was reand AIT during the			Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The Administrator will	
	facility failed to ma of monthly generate generator during 5 of 6.4.4.1.1.4(a) of 20	review and interview, the intain a complete written record or load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency		present the inspection/testing results at the Quality Assuran Performance Improvement (Comeeting. Results and system components will be reviewed the QA/PI Committee with	ce/ NA/PI)
	electrical system to 110, the Standard for Powers Systems, Cl NFPA 99 requires a	be in accordance with NFPA or Emergency and Standby napter 8. Chapter 6.4.4.2 of written record of inspection, using period, and repairs for the		subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction	
	generator to be regular for inspection by the	larly maintained and available e authority having eficient practice could affect all		constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 10/28/2024.	h
	a.m. and 11:30 a.m. Administrator-in-Tr was no documentati	riew on 10/15/24 between 9:00 with the Administrator and raining (AIT) present, there son on the generator monthly perage readings from May to			
September 2024. Based on interview at the time of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155217		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIEI S OF HUNTINGBU		1712 L	ADDRESS, CITY, STATE, ZIP COD ELAND DR NGBURG, IN 47542	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	record review, the were no amperage generator log between	Administrator confirmed there readings on the monthly een May and September 2024.			
K 0000					
Bldg. 01	Licensure Survey was Department of Hea 483.90(a) in conjur Complaint #IN004. Survey Date: 10/1: Facility Number: (Provider Number: AIM Number: 100) At this Life Safety Huntingburg was for Requirements for Provider Medicare/Medicaid Life Safety from Fire National Fire Prote Life Safety Code (In Health Care Occup) This one story facility Type V (000) const sprinklered. The fawith hard wired smand spaces open to operated smoke detrooms. The facility	5/24 000122 155217 0290560 Code survey, The Waters of bound not in compliance with	K 0000	Preparation and/or execution this plan of correction in gene or this corrective action, does constitute an admission or agreement by this facility of the facts alleged or conclusions of the facts alleged or con	eral, s not ne set stive state of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155217		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/15/2024	
	ROVIDER OR SUPPLIER		1712 L	ADDRESS, CITY, STATE, ZIP COD ELAND DR NGBURG, IN 47542	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0324	access were sprinkle facility services were wood sheds and one southwest exit used	residents have customary ered and all areas providing re sprinklered, except two e metal shed outside the for facility storage.			
SS=E Bldg. 01	Cooking Facilities				
	failed to ensure the in the Physical Ther switch when not in within a smoke commercial cooking prepare meals for 30 permitted, provided complies with all the (1) The space contais not a sleeping root (2) The space contashall be separated from plying with 19. (3) The requirement and (13) are met. 19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, if acility that deactive (b) The switch is us or range whenever to supervision. (c) The switch is on 120-minute capacity deactivates the cook staff action.	ining the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. Its of 19.3.2.5.3(1) through (10) A switch meeting all the	K 0324	k324— It is the intent of the factor to ensure the cook top for stove/oven in the physical there area is shut off at the switch work in use to meet set standard 1. CORRECTIVE ACTIONS TAKEN: a. On 10/28/2024 the electrician/maintenance supervisor/designee installed a lockable disconnect switch to the stove/oven in the physical there to meet set standards. The Administrator verified the work 10/28/2024. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff are visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. The Administrator inserviced Maintenance Supervisor / Physical therapy Director on 10/28/2024 the requirement to ensure the cook top for stove/oven in the physical therapy area is shut of and locked out at the disconners.	apy hen ds. a he apy on D: d the sical 4 on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155217	B. WING 10/15/2024			2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		1712 LELAND DR				
WATERS	OF HUNTINGBUR	RG, THE			NGBURG, IN 47542		
			-		, · · · · · · · · · · · · · · · · · · ·	ı	OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG		.4	DATE
	Therapy area.	isitors while in the Physical			switch when not in use to mee	et	
	Therapy area.				set standards.	~ <i>,</i>	
	Findings include:				b. The Maintenance Supervisor Physical Therapy Director will	וע / וע	
	r manigs include:				ensure the cook top for stove	oven	
	Based on observation	ons on 10/15/24 between 11:30			in the physical therapy area is		
		during a tour of the facility with			shut off and locked out at the		
	-	nd Administrator-in-Training			disconnect switch when not in	IISE	
		cooktop stove/oven in the			as a part of the facility's weekl		
		rea. The stove/oven was not			Preventive Maintenance Progr	-	
	being used at the time of observation and the				and document those inspectio		
	power to the stove/oven was on. Based on				results as appropriate. If any		
	*	e of observation, the			issues are discovered, they wi		
		rmed the cooktop stove/oven			addressed and resolved		
		when not in use, and further			immediately. The Maintenand	e l	
		oven in the Physical Therapy			Supervisor/designee will revie		
		ed with a disconnect switch		with the Administrator the			
	with a timer so Phys	sical Therapy staff could shut			inspection results.		
	the power off to the	stove/oven when not in use.			c. The Administrator will moni	tor	
					adherence to the Preventative	.	
	-	viewed with the Administrator			Maintenance schedule and		
	and AIT during the	exit conference.			validate the Preventative		
					Maintenance documentation is	s in	
	3.1-19(b)				place.		
					4. MONITORING CORRECTIV	/ E	
					ACTION:		
					a. The monitoring results will be		
					presented by the Administrato	r at	
					the monthly Quality		
					Assurance/Performance		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed the QA/PI Committee with	Ју	
					subsequent plans of correction	,	
					developed and implemented a		
					deemed necessary to ensure	ເວ	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
	i		1		,		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	ľ í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155217		A. BUILDING 01 B. WING		10/15/2024	
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD ELAND DR		
WATERS	OF HUNTINGBUR	RG, THE			NGBURG, IN 47542		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG			COMPLETION DATE
1710	REGELITORT OF	K ESC IDENTIFY TING IN ORDER THOS		mo	allegation of compliance wit	h	DATE
					all regulatory requirements.		
					Our date of compliance is		
					10/28/2024.		
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 01	, , , , , , , , , , , , , , , , , , , ,	J					
		view, observation, and	K 0	353	K353 – It is the intent of the		10/28/2024
		ity failed to document sprinkler			facility to ensure to document		
		in accordance with NFPA 25			sprinkler system inspections in		
	for 1 of 1 dry sprinkler system during 32 of the past 52 weeks for the sprinkler system's pressure gauges, and during 8 of the past 12 months for the				accordance with NFPA 25 for	dry	
					sprinkler system and for the		
		s of the past 12 months for the control valves. NFPA 25,			sprinkler system's control valv	/es	
		spection, Testing, and			to meet set standards. 1.CORRECTIVE ACTIONS		
		ater-Based Fire Protection			TAKEN:		
		tion, Section 5.2.4.2 states			1.On 10/28/2024 the		
	•	sprinkler systems shall be			Maintenance supervisor cond	ucted	
		o ensure that normal air and			the weekly inspection of the d		
		being maintained. Section			sprinkler system gauges and	,	
	5.1.2 states valves a	and fire department			documented the results in the		
		e inspected, tested, and			facilities life safety binder to m	neet	
		rdance with Chapter 13.			set standards. The Administra		
		ates Table 13.1.1.2 shall be			verified the work on 10/28/202	24 .	
	_	ion, testing and maintenance of			2.On 10/28/2024 the		
	-	be made for all inspections,			Maintenance Supervisor conducted the monthly sprinkl	lor	
		nce of the system and its			system control valves inspecti		
		all be made available to the			and documented the results in		
	-	risdiction upon request. This			facilities life safety binder to m		
		ould affect all residents, staff,			set standards. The Administra		
	and visitors in the f	facility.			verified the work on 10/28/202	24 .	
					2.ALL OTHERS WITH		
	Findings include:				POTENTIAL TO BE AFFECTI		
		10/15/611			1.All residents and all sta		
		review on 10/15/24 between			and visitors have the potential	l to	
		0 a.m. with the Administrator and			be affected but none were.	-	
		raining (AIT) present, there tion available to show the			3.MEASURES TO PREVEN REOCCURRENCE:	ı	
	mas no accumentat	ion available to show the	1		I NEGOCONNENCE.		I .

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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	
		155217	B. WI	NG		10/15/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ELAND DR		
\\/\TED		DC THE			NGBURG, IN 47542		
WATERS OF HUNTINGBURG, THE			HONTH	NGBORG, IN 47542			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		der system gauges were			1.On 10/28/2024 the		
		uring 32 of the past 52 week			Administrator in serviced the		
	-	veekly sprinkler gauge			Maintenance Supervisor/desig	gnee	
	_	or the weeks between May 13			on the requirement to ensure	the	
		024. Based on interview at the			weekly dry sprinkler system		
		ew, the Administrator confirmed			gauges inspection and the		
		nentation available to show			monthly sprinkler system cont		
		orinkler gauges had been			valves inspection is conducted	d and	
	•	veekly during 32 of the past 52			documented to meet set		
		bservations on 10/15/24			standards.		
	between 11:30 a.m. and 2:00 p.m. during a tour of				2.Maintenance		
	the facility with the Administrator and AIT the				Supervisor/designee will ensu		
	facility had three pressure gauges at the sprinkler				the weekly dry sprinkler syste	m	
	riser.				gauges inspection and the		
					monthly sprinkler system cont		
		review on 10/15/24 between			valves inspection is conducted	d and	
		a.m. with the Administrator and			documented as a part of the		
		raining (AIT) present, there			facility's Preventive Maintenar		
		rinkler system control valves			Program and document those		
	_	ntation for 8 of the past 12			inspection results as appropri		
		monthly inspections available			If any issues are discovered, t	-	
		, August, and October of 2024.			will be addressed and resolve		
		at the time of record review,			immediately. The Maintenand		
		confirmed the lack of sprinkler			Supervisor/designee will revie	W	
		on the control valves during 8			with the Administrator the		
	the past 12 months.				inspection results.		
	This finalin	eviagrad with the Admin't			3.The Administrator will		
	_	eviewed with the Administrator			monitor adherence to the		
	and AIT during the	exit conference.			Preventative Maintenance		
	2.1.10(1-)				schedule and validate the		
	3.1-19(b)				Preventative Maintenance		
					documentation is in place.	N/E	
					4.MONITORING CORRECT	IVE	
					ACTION:	azill	
					1.The inspection results		
					be presented by the Maintena	rice	
					Supervisor/designee to the	ļ	
					Administrator monthly and the	<i>!</i>	
					Administrator will present the	L. L	
		1		inspection results at the month	אור		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155217	B. WING 10/15/2024			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			l	ELAND DR		
WATERS	OF HUNTINGBUR	RG, THE		HUNTINGBURG, IN 47542			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DLAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
					Quality Assurance/Performand	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	оу	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	ıs	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	า	
					all regulatory requirements.		
					Our date of compliance is		
					10/28/2024.		
K 0712	NFPA 101						
SS=C	Fire Drills						
Bldg. 01	The Billio						
5	Based on record rev	view and interview, the facility	K 0	712	K712 –It is the intent of the fac	cility	10/28/2024
		12 fire drill reports included	110	, 12	to ensure fire drill reports inclu	•	10/20/2021
		ation of the transmission of a			complete documentation of the		
	fire alarm signal to	the monitoring company/fire			transmission of a fire alarm sig		
	department during t	he past twelve months. LSC			to the monitoring company/fire	,	
	19.7.1.4 requires fir	e drills in health care			department during the past tw	elve	
	occupancies shall in	clude the transmission of the			months to meet set standards		
	~	d simulation of emergency			1 CORRECTIVE ACTIONS	3	
	conditions. This de	ficient practice could affect all			TAKEN:		
	residents.				a On 10/28/2024 the		
					Maintenance Supervisor		
	Findings include:				conducted fire drills and record		
					the time the monitoring compa	-	
		the facility's fire drill reports			received the transmission of the	ne	
		n 9:00 a.m. and 11:30 a.m. with			fire alarms to meet set		
		nd Administrator-in-Training			standards.		
		drill reports dated 05/07/24 at			2 ALL OTHERS WITH		
	-	5/24 at 1:30 p.m., were not			POTENTIAL TO BE AFFECTE		
		uate documentation for the			a All residents and all staff		
		alarm to the monitoring			and visitors have the potential	το	
	company. Only the	date of the fire drill was			be affected but none were.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER 155217	A. BUILDING B. WING	01	COMPLETED 10/15/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1712 LELAND DR HUNTINGBURG, IN 47542				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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		
	received the transmi on interview at the t Administrator confi- information include to verify that transmi received by the more	viewed with the Administrator		REOCCURENCE: a Administrator inserviced Maintenance Supervisor/design on 10/28/2024 to ensure fire of are conducted and include on fire drill documentation sheet recording of the time the monitoring company received transmission of the fire alarm part of the facility's monthly Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they waddressed and resolved immediately. The Maintenance Supervisor/designee will reviewith 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 fire drill documentation will be presented by the Maintenance Supervisor/design to the Administrator monthly at the Administrator will present inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of corrections.	gnee drills the the the as a ram on ill be be ww dion gnee and the hly ce j. by		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155217	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/15/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1712 LELAND DR HUNTINGBURG, IN 47542					
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
				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 10/28/2024.				
K 0761 SS=F Bldg. 01	Based on record revinterview, the facility rolling fire door in a Standard for Fire D Protectives, 2010 Edevice, equipment, arrangement, level of feature is required for provision of this Cosystem, condition, a protection, or other maintained unless the maintained unless the maintained unless than annually, and a inspection shall be s	of protection, or any other for compliance with the de, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such A 80 5.2.1 requires fire door inspected and tested not less a written record of the signed and kept for inspection efficient practice could affect all	K 0761	K761 – It is the intent of the facility to ensure to maintain rolling fire doors in accordance with NFPA 80, Standard for Fir Doors and Other opening protectives, 2010 edition to me set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 10/23/2024 the facilit licensed fire protection compar conducted the annual rolling fir door inspection and document the information in the life safety binder to meet set standards. Administrator verified the work 10/23/2024. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVENTING TO THE TO	eet ies ny ee ed y The on D:			

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fire door between the kitchen and dining room

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maintenance Supervisor on the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/15/2024 155217 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1712 LELAND DR WATERS OF HUNTINGBURG, THE HUNTINGBURG, IN 47542 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was on the fire alarm system inspection report annual inspecting and testing of dated 01/18/24 which stated in the remarks section the rolldown door assemblies to "Kitchen Roll Door Release Box did not activate meet set standards. on Alarm." Based on interview during record Maintenance review, the Administrator said this was the only Supervisor/designee will ensure report available that included information about the annual inspection and testing the kitchen rolling fire door, but agreed the report of fire door assemblies is only addressed the roll door release box and not conducted as a part of the the entire fire roll door assembly. Furthermore, the facility's annual Preventive Administrator said the roll door release box still Maintenance Program and does not release the rolling metal door when the document those inspection results fire alarm system is activated, but the kitchen staff as appropriate. If any issues are has been instructed to manually close the door in discovered, they will be addressed the event the fire alarm system is activated. This and resolved immediately. The was confirmed by the kitchen manager during a Maintenance Supervisor/designee tour of the kitchen between 11:30 a.m. and 2:00 will review with the Administrator p.m. the inspection results. The Administrator will This finding was reviewed with the Administrator monitor adherence to the and AIT during the exit conference. Preventative Maintenance schedule and validate the 3.1-19(b) 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155217		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIED		1712	ET ADDRESS, CITY, STATE, ZIP COD 2 LELAND DR NTINGBURG, IN 47542	
(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 CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION PRIATE DATE
				This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance is 10/28/2024.	ts.
K 0916 SS=F Bldg. 01	NFPA 101 Electrical System	s - Essential Electric Syste			
	failed to ensure 1 of provided with an all readily observed by regular work station NFPA 99, 2012 Ed Code, at 6.4.1.1.17 that is storage batted to operate outside of location readily observed at a regular work state be hard-wired to in emergency or auxil (1) Individual visus a. When the emerging is operating to supply b. When the batter (2) Individual visus audible signal to we alarm condition shates. Low lubricating b. Low water temply c. Excessive water d. Low fuel when a contains less than a e. Overcrank (failed f. Overspeed. Where a regular work periodically, an auxiliary of the provided by the state of the provided by the state of the provided by the provid	y charger is malfunctioning. al signals plus a common arn of an engine-generator all indicate: oil pressure. perature. temperature. the main fuel storage tank 4-hour operating supply.	K 0916	K0916– It is the intent of the facility to ensure emergency generator is provided with a annunciator in a location resobserved by operating persent at a regular work station surposes at a regular work station and to main complete written record of generator load testing for generator during all 12 months year to meet set standad 1 CORRECTIVE ACTION TAKEN: a On 10/28/2024 the falicensed generator contract relocated the alarm annuncy the occupied unit 1 nurses to meet set standards. The Administrator verified the word 10/28/2024. b On 10/23/2024 the Maintenance Supervisor conducted the monthly load testing of the generator and documented the results in facilities life safety binder to set standards. The Administrator verified the word 10/28/24	an alarm eadily sonnel uch as ntain a monthly nths of ards. DNS acilities ttor ciator to ' station The vork d d the o meet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED			
155217		155217	B. WING 10/15/20			2024			
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER					ELAND DR				
WATERS OF HUNTINGBURG, THE					NGBURG, IN 47542				
	1		1		, T	1	OV.C.		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG		a LSC IDENTIFYING INFORMATION onitored location. This		TAG	POTENTIAL TO BE AFFECTE	-D:	DATE		
	1	shall activate when any of the							
		1.17(1) and (2) occur but need			a All residents and all staft and visitors have the potential				
		onditions individually. This			be affected but none were.	ιο			
		ould affect all residents, as well			3 MEASURES TO PREVENT				
	as visitors and staff				REOCCURRENCE:				
					a On 10/28/2024 the				
	Findings include:				Administrator inserviced the				
	<i>3</i>				Maintenance Supervisor/designee				
	Based on observation	on on 10/15/24 between 11:30			on the requirement to ensure				
		during a tour of the facility with			generator alarm annunciator is				
	the Administrator a	nd Administrator-in-Training			located in a location readily				
	(AIT), the remote g	enerator annunciator panel			observed by operating person	nel			
	was located at the U	Jnit 2 Nurse's Station which			and to ensure monthly genera	tor			
	was not currently in	operation. When asked, the			load testing is being complete	d			
	Administrator said Unit 2 is currently closed due				and documented in the life sa	fety			
	to a low census. There are no residents currently				binder to meet set standards.				
	on Unit 2 and the nearest Nurse's Station is				b The Maintenance Super	visor			
	located on the Memory Care, which was down a				/designee will ensure the				
	_	n the other side of a set of			generator alarm annunciator is	S			
	smoke barrier doors. The generator annunciator				located in a location readily				
	panel would not be heard or seen from the				observed by operating personnel				
	Memory Care Nurse's Station if activated.				and will ensure monthly gener				
					load testing is being completed				
	This finding was reviewed with the Administrator				and documented in the facilitie	es			
	and AIT during the exit conference.				life safety binder to meet set				
	21.10(1)				standards.				
	3.1-19(b)				c The Administrator will				
					monitor adherence to the	:			
					Emergency Preparedness Polymanual and validate the	icy			
					documentation is in place. 4 MONITORING				
					CORRECTIVE ACTION:				
					a The Administrator will				
					present the inspection/testing				
					results at the Quality Assurance	ce/			
					Performance Improvement (Q				
					meeting. Results and system				
					components will be reviewed				

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CENTERS FO	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155217		IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) date survey completed 10/15/2024	
NAME OF	PROVIDER OR SUPPLIE	3		ADDRESS, CITY, STATE, ZIP COD ELAND DR		
WATER	S OF HUNTINGBUI	RG, THE	HUNTI	NGBURG, IN 47542		
(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 APPROPRIAT DEFICIENCY)	(X COMPLI DAT	ETION
				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 10/28/2024.	5	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 5 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:		K 0918	K918 – It is the intent of the facility to ensure to maintain a complete written record of mongenerator load testing for the generator to meet set standard 1 CORRECTIVE ACTIONS TAKEN: a On 10/28/2024 the Maintenance Supervisor/design conducted the load testing of the emergency generator and recorded the amperage reading and documented the results in facilities life safety binder to me set standards. The Administrator verified the work 10/28/2024. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE	s. nee ne gs the eet	2024
	a.m. and 11:30 a.m	with the Administrator and raining (AIT) present, there		a All residents and all staff and visitors have the potential		

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was no documentation on the generator monthly

load test log for amperage readings from May to

September 2024. Based on interview at the time of

record review, the Administrator confirmed there

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REOCCURRENCE:

be affected but none were.

MEASURES TO PREVENT

The Administrator inserviced

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155217		B. WING 10/15/2024			2024		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ELAND DR		
WATERS OF HUNTINGBURG, THE					NGBURG, IN 47542		
			1		, - I		ar.
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL						COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	were no amperage readings on the monthly			the Maintenance Supervisor/designee on			
	generator log between May and September 2024.				Supervisor/designee on 10/28/2024 the requirement to		
	This finding was reviewed with the Administrator				ensure a load bank test is	,	
	and AIT during the				conducted on the emergency		
	and the during the	CAR COMOTONICE.			generator including the amperage		
	3.1-19(b)				readings and documented in t	-	
					life safety binder to meet set		
					standards.		
					b The Maintenance		
					Supervisor/designee will ensu	re a	
					load bank test is conducted or		
					emergency generator including		
					amperage readings and	-	
					documented in the life safety		
					binder as a part of the facility's	3	
					monthly Preventive Maintenar	nce	
					Program and document those		
					inspection results as appropria		
					If any issues are discovered, t	-	
					will be addressed and resolve		
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					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 w	ill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performand	-	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155217	î ´	ILDING	onstruction 01	(X3) DATE COMPL 10/15	LETED
NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1712 LELAND DR HUNTINGBURG, IN 47542				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented at deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/28/2024.	oy n as	

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