	K MEDICARE & MEDIC				OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155223	B. WING	10/24/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)			
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 10/24 Facility Number: 0 Provider Number: 1000 At this Emergency Waters of Covingto compliance with Er Requirements for M Participating Provide 483.73.	00128 155223 289650 Preparedness survey, The n was found not in nergency Preparedness fedicare and Medicaid ders and Suppliers, 42 CFR	E 0000				
E 0041 SS=F	The facility has 119 certified beds. At the time of the survey, the census was 82. Quality Review completed on 10/25/24 482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power						
Bldg	Based on record rev failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). Findings include: 1. Based on records Generator - Monthly	riew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 review of 'Emergency y Test Log' with the or on 10/24/24 between 10:15	E 0041	E041– It is the intent of the facto ensure to implement the emergency power system inspection, testing and maintenance requirements for in the Health Care Facilities Con NFPA 110 and Life Safety Cocaccordance with 42 CFR 483. (E) (2) to meet set standards. CORRECTIVE ACTIONS TAKEN:	and ode, de in 73		

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

(X6) DATE

TITLE

Lisa Foreman Administartor 11/11/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MNLH21 Facility ID: 000128 If continuation sheet Page 1 of 26

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 10/24	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP CO E LIBERTY ST NGTON, IN 47932	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	was exercised less talest twelve months. load for 10 to 20 m. February, April, Julion interview at the Maintenance Direction for five weeks a monthly test logs strun for the required twelve months. 2. Based on review Checklist" document Director during rectional process of the second of the sec	the generator set in service than 30 minutes for four of the The generator was ran under inutes for the months of y and September 2024. Based time of record review, the for stated he had been on the and agreed that the provided nowed the generator did not 30 minutes for 4 of the last of "Weekly Inspection and the model of the weekly Inspection of the weekly or inspections for two weeks in available for review. Based on the for stated he had been on the model of the weekly energency generator aforementioned time frames the weekly energency generator aforementioned time frames the weekly with the model of the weekly with the model of the weekly energency generator aforementioned time frames the weekly energency energy ene		a On 10-29-2024 the Maintenance Supervisor completed the monthly letesting of the emergency generator which included minute test and docume results in the facilities Lit Binder to meet set stand. The Administrator verified 10-30-2024 boon_10-25-2024 the Maintenance Supervisor completed the weekly in of the emergency generator documented the results facilities Life Safety Binder to week set standards. The Administrator verified the 10-30-2024 completed the weekly in meet set standards. The Administrator verified the 10-30-2024 completed the weekly in a complete set standards. The Administrator in the policy of the emergency generator in the requirement that sominute load bank tess weekly inspection of the emergency generator is and document the result Life Safety Binder to me standards. The Maintenance is a minute load bank test are inspection of the emergency generator in the standards.	oad bank y d a full 30 nted the fe Safety dards. ed the work he spection ator and in the der to the e work TH FECTED: Ill staff tential to re. REVENT e the r/designee a monthly t and required as in the et set Supervisor monthly 30 nd weekly	

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 10/24/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN	THE 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-REFERENCE TO THE APPROPRIAL DEFICIENCY) generator is conducted and document the results in the Lift Safety Binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Pol Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a At least every month the load bank testing will be completed and weekly inspect of the generator will be conduct to ensure compliance; the Administrator and Maintenanc Supervisor/designee will reviee Emergency Preparedness Pol Manual and make changes as necessary to meet set standar Those reviews will be docume as appropriate. The Administra will present the training results the Quality Assurance/ Performance Improvement (Queeting). Results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	icy ion cted e w the icy ds. nted ator at A/PI)	(X5) COMPLETION DATE
					Our date of compliance is 11/15/2024		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet

Page 3 of 26

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/24/2024			
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932	
(X4) ID PREFIX TAG K 0000	(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/24 Facility Number: 0 Provider Number: 1002 At this Life Safety C Covington was four Requirements for Pa Medicare/Medicaid. Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one-story facil: Type V (000) constracility has a fire ala detection in the corr corridors, and batter in all resident sleepi capacity of 119 and of this visit. All areas where resi were sprinkled and services were sprink	200128 155223 289650 Code survey, The Waters of and not in compliance with articipation in 42 CFR Subpart 483.90(a), and the 2012 edition of the etion Association (NFPA) 101, and articipation in 42 CFR Subpart 483.90(a), and the 2012 edition of the etion Association (NFPA) 101, and and 410 IAC 16.2. The arm system with smoke etidors, spaces open to the arm system with smoke etidors, spaces open to the arm system with smoke etidors, and a detectors are rooms. The facility has a had a census of 82 at the time dents have customary access all areas providing facility cled except for two detached detached Garage which were	K 0000		
	•		•	•	ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet Page 4 of 26

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 10/24/2024 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0300 NFPA 101 SS=F Protection - Other Bldg. 01 Based on record review, interview and K 0300 **K300**– It is the intent of the facility 11/15/2024 observation, the facility failed to ensure to ensure documentation for the documentation for the preventative maintenance preventative maintenance of of 69 of 69 battery operated smoke alarms in battery operated smoke alarms in resident rooms was complete. NFPA 101 in resident rooms is complete to 4.6.12.3 states existing life safety features obvious meet set standards. to the public, if not required by the Code, shall be 1 **CORRECTIVE ACTIONS** maintained. NFPA 72, 29.10 Maintenance and TAKEN: Tests. Fire-warning equipment shall be maintained On 10-30-2024 the and tested in accordance with the manufacturer's Maintenance Supervisor/designee published instructions and per the requirements performed the weekly testing of of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, the resident room battery operated testing, and maintenance programs shall satisfy smoke alarm in all resident rooms the requirements of this Code and conform to the including room 25 to meet set equipment manufacturer's published instructions. standards. The Administrator This deficient practice could affect all residents, verified the work on 10-31-2024 staff, and visitors. **ALL OTHERS WITH** POTENTIAL TO BE AFFECTED: Findings include: All residents and all staff and visitors have the potential to Based on review of the Battery Operated Smoke be affected but none were. Detector Maintenance Logs on 10/24/24 from **MEASURES TO PREVENT** 10:15 a.m. to 12:45 p.m. with the Maintenance REOCCURRENCE: Director present, the resident room battery On 10/31/2024 the operated smoke alarms were tested on a monthly Administrator inserviced the basis during the past twelve months. Based on Maintenance Supervisor/designee observation with the Maintenance Director during on the requirement to ensure all a tour of the facility, the battery operated smoke battery operated smoke alarms detector located in resident room #25 was a Kidde are maintained and tested per model i9010 and requires weekly testing. Based on manufactures guidelines to meet interview at the time of review and observation, set standards. the Maintenance Director stated that all Maintenance battery-operated smoke detectors in the facility Supervisor/designee will ensure all are tested monthly and confirmed that battery-operated smoke alarms manufacturers instructions of the one in resident are maintained and tested per room #25 called for weekly testing. There was manufactures guidelines (weekly) documentation showing that all battery smoke and will document the results on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155223	B. WING 10/24/2024			2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WATERS OF COVINGTON, THE				LIBERTY ST			
WATERS	OF COVINGTON,	IHE		COVIN	GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	detectors were repla	aced October 2023. The			the Battery-Operated Smoke		
	Maintenance Direct	tor stated he would start			Detector Maintenance Log to	be	
	performing testing	as required by manufacture's			filed in the Life Safety Binder a		
	instruction.				part of the facility's Preventive		
					Maintenance Program. If any		
	This finding was re	viewed with the Administrator			issues are discovered, they w		
		irector at the exit conference.			addressed and resolved		
					immediately. The Maintenance	e	
	3.1-19(c)				Supervisor/designee will revie		
					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/Performan	•	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed l		
					the QA/PI Committee with	-	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	n	
					all regulatory requirements.		
					Our date of compliance is		
					11/15/2024		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE (A. BUILDING B. WING	<u> </u>		
	PROVIDER OR SUPPLIER		1600 I	FADDRESS, CITY, STATE, ZIP COD E LIBERTY ST NGTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=D Bldg. 01		on and interview, the facility	K 0321		11/15/2024
	as Laundries (larger were separated from resistant partitions a closing or automatic 7.2.1.8. This deficit the vicinity of the L hall. Findings include:	Fover 8 hazardous areas such than 100 square feet in size) in other spaces by smoke and doors. Doors shall be self acclosing in accordance with ent practice could affect staff in aundry Room in the service		k321– It is the intent of the factor to ensure hazardous areas sure as laundries are separated from other spaces by smoke resistan partitions and doors to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 10/25/2024 the Maintenance Supervisor/designer removed the wooden wedge from the standards.	ch m ant et 3 gnee rom
	Director during a to p.m. to 3:05 p.m. or the Laundry Room facility was propped the Laundry Room closing device and I door into the door fi with a wooden wedgon interview at the the Maintenance Direct hazardous area was spaces by smoke reswith the door being	ons with the Maintenance our of the facility from 12:45 in 10/24/24, the corridor door to in the service hall wing of the di open. The corridor door to was equipped with a self atching hardware to latch the rame but was propped open ge placed on the floor. Based time of the observations, the or agreed the aforementioned not separated from other sistant partitions and door propped open.		the corridor door to the laundry room to meet set standards. T Administrator verified the work 10/25/2024. 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 PREVEINGE REOCCURRENCE: a On 10/25/2024 the Administrator inserviced the Maintenance Supervisor/all laundry and housekeeping stapped to the staff on the requirement.	the to MT ff/all
	-	viewed with the Administrator e Director during the exit		other staff on the requirement ensure hazardous areas are equipped with a self-closing do and to ensure doors are not propped open to meet set standards. b Maintenance Supervisor/designee will ensure hazardous areas are equipped with a self-closing devices so the standards.	oor re

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/24/2024	
	ROVIDER OR SUPPLIED		1600 E	ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST IGTON, IN 47932	
(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 APPROPRIA DEFICIENCY) self-close, shut and latch and	DATE
				ensure doors are not propped open as a part of the facility's monthly Preventive Maintenar Program and document those inspection results as appropriated any issues are discovered, the will be addressed and resolve immediately. The Maintenand Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. MONITORING CORRECTIVE ACTION: The inspection results we be presented by the Maintenance Supervisor/designee to the Administrator will present the 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 correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with	rill ince ship ce they do ce they
				all regulatory requirements.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet

Page 8 of 26

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. Building <u>01</u>			COMPLETED	
		155223	B. WING 10/24/2024					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	.16	DATE	
					11/15/2024			
K 0351 SS=E Bldg. 01	failed to maintain the facility in accordance the Installation of S 2010 edition, Section escutcheons, or other annular space around or shall be listed for deficient practice corresidents in the Foundament. Findings include: Based on observation Director on 10/24/2 from 12:45 p.m. to do by the Fountain Wirescutcheon. There we exposed the attic spanisher in houseked Therapy had a mission interview at the time Maintenance Direct were missing in each of the state of the	on and interview, the facility the ceiling construction in the the with NFPA 13, Standard for prinkler Systems. NFPA 13, on 6.2.7.1 states plates, or devices used to cover the d a sprinkler shall be metallic, or use around a sprinkler. This could affect staff and up to 43 ontain Wing smoke on with the Maintenance 4 during a tour of the facility 3:05 p.m., the clean linen room ong nurse station had a missing was a 1/2 inch gap that ace. Additionally, the the peping storage room by sing escutcheon. Based on the of observations, the or confirmed the escutcheons	K 0	351	K351 - It is the intent of the facto ensure to maintain the ceiling construction in the facility in accordance with NFPA 13, standard for installation of sprinkler systems to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 11/11/2024 the Maintenance Supervisor/designistalled the escutcheon rings the clean linen room by the fountain wing nurses station at the housekeeping storage rootherapy to meet set standards. The Administrator verified the on 11/11/2024. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE at All residents and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVER REOCCURRENCE: a On 10/31/2024t Administrator in serviced the Maintenance Supervisor/designing construction including the sprinkler head escutcheon ring meet set standards.	gnee in and in a	11/15/2024	
					b Maintenance Supervisor/designee will ensu	re to		

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155223	B. W	ING		10/24/2024		
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			LIBERTY ST			
WATER	S OF COVINGTON	TUE			GTON, IN 47932			
WATERS	S OF COVINGTON	,		COVIN	G10N, IN 47932			
(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	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					maintain ceiling construction			
					including the sprinkler head			
					escutcheon rings as a part of	the		
					facility's Monthly Preventive			
					Maintenance Program and			
					document those inspection re-			
					as appropriate. If any issues			
					discovered, they will be addre			
					and resolved immediately. The			
					Maintenance Supervisor/design	-		
					will review with the Administra	itor		
					the inspection results.			
					c The Administrator will			
					monitor adherence to the			
					Preventative Maintenance			
					schedule and validate the			
					Preventative Maintenance			
					documentation is in place.			
					4 MONITORING			
					CORRECTIVE ACTION:	•••		
					a The inspection results w			
					be presented by the Maintena	ince		
					Supervisor/designee to the			
					Administrator monthly and the	;		
					Administrator will present the	hlv.		
					inspection results at the month Quality Assurance/Performan	•		
					Improvement (QA/PI) meeting			
					Inspection results and system	•		
					components will be reviewed			
					the QA/PI Committee with	y		
					subsequent plans of correctio	n		
					developed and implemented a			
					deemed necessary to ensure			
					compliance is maintained.			
					This plan of correction			
					constitutes our credible			
					allegation of compliance wit	h		
					all regulatory requirements.			
					Our date of compliance is			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet

Page 10 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155223 B. WING 10/24/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 11/15/2024. K 0355 **NFPA 101** SS=D Portable Fire Extinguishers Bldg. 01 1. Based on observation and interview, the facility K 0355 **K355**– It is the intent of the facility 11/15/2024 failed to maintain 1 of 1 portable K Class fire to ensure to maintain portable K extinguishers in the kitchen cooking area in class fire extinguishers in the accordance with the requirements of NFPA 10. kitchen cooking area in NFPA 10, Standard for Portable Fire Extinguishers, accordance with the requirements 2010 Edition, Section 5.5.5 states fire extinguishers of NFPA 10 and to ensure portable fire extinguishers are installed in provided for the protection of cooking appliances using combustible cooking media (vegetable or accordance with NFPA 10 to meet animal oils and fats) shall be listed and labeled for set standards. Class K fires. NFPA 10, 5.5.5.3 states a placard **CORRECTIVE ACTIONS** shall be placed near the extinguisher that states TAKEN: that the protection system shall be actuated prior On 11/11/2024 the to using the fire extinguisher. Since the fixed fire Administrator/Maintenance extinguishing system will automatically shut off Supervisor/designee installed a the fuel source to the cooking appliance, the fixed placard by the portable K class system should be activated before using the fire extinguisher in the kitchen portable fire extinguisher. In this instance, the stating the fire protection system portable fire extinguisher is supplemental shall be activated prior to using protection. This deficient practice could affect the fire extinguisher to meet set five staff and visitors in the kitchen. standards. The Administrator verified the relocation on Findings include: 11/11/2024 On 11/11/2024 the Based on observation with the Maintenance Maintenance Supervisor/designee Director during a tour of the facility at 2:05 p.m. on relocated the K class fire 10/24/24, a portable K Class fire extinguisher was extinguisher located in the kitchen located in the kitchen and a placard was not so it is mounted with the top of the conspicuously placed near the extinguisher which extinguisher no greater than five states the fire protection system shall be activated feet above the floor when prior to using the fire extinguisher. Based on measured to meet set standards. interview at the time of observation, the The Administrator verified the Maintenance Director confirmed a placard was not relocation on 11//11/2024. conspicuously placed near the extinguisher which **ALL OTHERS WITH** states the fire protection system shall be activated **POTENTIAL TO BE AFFECTED:** prior to using the fire extinguisher.

All residents and all staff

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155223	B. W	ING		10/24/	2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			LIBERTY ST		
\\\\ATEDS	OF COVINGTON,	THE			GTON, IN 47932		
WAIERS	or coving roll,	11115		COVING			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
					and visitors have the potential	to	
		ation and interview, the facility			be affected but none were.		
		f 26 portable fire extinguishers			3 MEASURES TO PREVE	NT	
		cordance with NFPA 10.			REOCCURRENCE:		
		for Portable Fire Extinguishers,			a On 10/31/2024 the		
		on 6.1.3.8.1 states fire			Administrator inserviced the		
	-	g a gross weight not			Maintenance Supervisor/and a		
	_	all be installed so that the top			dietary staff on the requiremer		
	•	her is not more than five feet			that portable fire extinguishers		
		is deficient practice could			must have placards stating the	e fire	
	affect 5 staff and vi	sitors in the kitchen.			protection system shall be		
					activated prior to using the fire	;	
	Findings include:				extinguisher and must not be		
					installed higher than 5 feet fro		
		on with the Maintenance			floor when measured to meet	set	
	_	our of the facility at 2:05 p.m. on			standards.		
	-	ole K Class fire extinguisher			b Maintenance		
		en was mounted on the wall			Supervisor/designee will ensu		
	_	extinguisher 5 feet 8 inches			portable fire extinguishers hav		
		sed on interview at the time of			placards stating the fire protec		
		intenance Director confirmed			system shall be activated prior		
	_	er was mounted with the top of			using the fire extinguisher and		
		eater than five feet above the			must not be installed higher th		
	floor when measure	ed.			feet from floor when measured	d as	
					a part of the facility's monthly		
	These findings were				Preventive Maintenance Progr		
		Maintenance Director at the			and document those inspectio		
	exit conference.				results as appropriate. If any		
					issues are discovered, they wi	ll be	
	3.1-19(b)				addressed and resolved		
					immediately. The Maintenance		
					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.		

DEPARTMENT OF HEALTH AND HUMAN SERVIC	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	ES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		A. BUILDING <u>01</u> B. WING			COMPLETED 10/24/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(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)	ΓE	(X5) COMPLETION DATE
					4 MONITORING CORRECTIVE ACTION: a The inspection results wi be presented by the Maintenar Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting. Inspection results and system components will be reviewed be the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.	nce ally be by n s	
K 0374 SS=E Bldg. 01	Barrie Based on observation failed to ensure 1 of restrict the movemen minutes. LSC, Section in smoke barriers shapped as the minimum clearance which is defined as movement of smokes.	and interview, the facility 10 sets of barrier doors would not of smoke for at least 20 on 19.3.7.8 requires that doors all comply with LSC, Section 8.5.4.1 requires doors in smoke opening leaving only the necessary for proper operation 1/8 inch to restrict the 2. This deficient practice as well as 4 staff and 2	K 03	374	K374 – It is the intent of the facility to ensure sets of barrier doors would restrict the moven of smoke for at least 20 minute to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 11/11/2024 the Maintenance Supervisor/desig repaired the barrier door set by medical records to ensure it closes fully to meet set standards. The Administrator	nent es nee	11/15/2024

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155223	B. WI	NG		10/24/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	IR.			LIBERTY ST		
WATERS	S OF COVINGTON	THE			GTON, IN 47932		
WithEnd				OOVIIV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				verified the repairs on		
					_11/11/2024		
		ions made on 10/24/24 during a			2 ALL OTHERS WITH		
	-	at 1:55 p.m. with the			POTENTIAL TO BE AFFECT		
		etor, the barrier door set by			a All residents and all staf		
		ailed to fully close smoke tight			and visitors have the potentia		
		ch gap when closed to their			be affected but none were. O	n	
		nterview at the time of			11/8/2024 the Maintenance		
	· · · · · · · · · · · · · · · · · · ·	laintenance Director confirmed			Supervisor/designee inspecte		
		or at the door set did not			smoke barrier doors througho		
		when the doors were tested and			the facility and found no other		
	they did not close	completely.			negative findings.		
					3 MEASURES TO PREVE	NT	
		eviewed with the Administrator			REOCCURRENCE:		
	and Maintenance I	Director at the exit conference.			a On 10/31/2024 the		
	2.1.10(1)				Administrator in serviced the		
	3.1-19(b)				Maintenance Supervisor/design	-	
					and all staff the requirement t		
					smoke barrier doors must res		
					fire for 20 minutes and have r	10	
					penetrations to meet set		
					standards.		
					b Maintenance		
					Supervisor/designee will inspe		
					all smoke barrier doors through		
					the facility monthly to ensure are maintained and have a	iney	
						of	
					20-minute fire rating as a part	OI	
					the facility's Preventive Maintenance Program and		
					document those inspection re	sulte	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. The		
					Maintenance Supervisor/design		
					will review with the Administra	-	
					the inspection results.	1.01	
					c The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
I	Ī		1		1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet

Page 14 of 26

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155223	A. BUILDING B. WING	01	COMPLETED 10/24/2024			
	ROVIDER OR SUPPLIER OF COVINGTON,		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.	nity ce . by nis			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills							
	failed to conduct qu quarters. LSC 19.7. conducted quarterly conditions. This def and residents. Findings include:	iew and interview, the facility arterly fire drills for 1 of 4 1.6 requires drills to be on each shift under varied icient practice affects all staff iew of the "Fire Drill Report"	K 0712	K712 –It is the intent of the facto ensure to conduct fire drills all 4 quarters to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On will be completed on 11/12/2024 the Maintenance Supervisor conducted fire drills	for S			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $\begin{array}{lll} MNLH21 & {\it Facility ID:} & 000128 \end{array}$

If continuation sheet

Page 15 of 26

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/24/2024 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE forms with the Maintenance Director on 10/24/24 including for the third shift and at 10:33 a.m., there was no documentation for a documented the information in the third shift fire drill in the first quarter (January, facilities life safety binder to meet February, or March) of 2024. There was a day shift set standards. On will be verified and two evening shift fire drills conducted on the on 11/12/2024 the Administrator first quarter. Based on interview at the time of confirmed the drill. record review, the Maintenance Director stated he **ALL OTHERS WITH** has been on the job for five weeks and that there **POTENTIAL TO BE AFFECTED:** are not any additional fire drills available for All residents and all staff review at the time of this survey. and visitors have the potential to be affected but none were. This finding was reviewed with the Administrator MEASURES TO PREVENT and Maintenance Director at the exit conference. REOCCURRENCE: On _10/31/2024_ the 3.1-19(b) Administrator inserviced the 3.1-51(c)Maintenance Supervisor/designee on the requirement to ensure fire drills are conducted quarterly, on each shift, under varying conditions to meet set standards. Administrator inserviced Maintenance Supervisor/designee to ensure fire drills are conducted quarterly, on each shift, under varying conditions, as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024	DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	N	
				4 MONITORING CORRECTIVE ACTION: a The fire drill documentativill be presented by the Maintenance Supervisor/design to the Administrator monthly at the Administrator will present the inspection results at the month 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 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 11/15/2024.	gnee nd the nlly ce by		
K 0753 SS=E Bldg. 01	failed to ensure 10 contain decorations of the door. LSC 13 decorations shall be occupancy, unless comet: (1) They are flame-	on and interview, the facility of over 50 corridor doors that did not exceed 30 percent 8.7.5.6 states combustible prohibited in any health care one of the following criteria is retardant or are treated with	K 0753	K753– It is the intent of the facto ensure corridor doors contated decorations that did not exceet percent of the door to meet sestandards. 1. CORRECTIVE ACTIONS TAKEN:	in ed 30 et	:4	
		lant coating that is listed and on to the material to which it is		a. On 10/25/2024 the Maintena Supervisor/designee removed plastic Halloween themed			

(2) The decorations meet the requirements of

sheeting decorations from the

PRINTED: 11/15/2024 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPI	LETED
		155223	B. WING			10/24	/2024
NAME OF	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZIP COD		
WATER	S OF COVINGTON,	, THE			GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE
	NFPA 701, Standar	rd Methods of Fire Tests for			following locations: 1. In the c	enter	
	Flame Propagation	of Textiles and Films.			corridor: Medical records offic	e,	
	(3) The decorations	s exhibit a heat release rate not			housekeeping, skilled med roo	om,	
	exceeding 100 kW	when tested in accordance with			skilled clean linen, classroom,	ı	
	NFPA 289, Standar	rd Method of Fire Test for			admissions and housekeeping	3	
	Individual Fuel Pac	ckages, using the 20 kW			closet and 2. In the freedom w	ving:	
	ignition source.				the nurse station door, resider	nt	
	(4)*The decoration	s, such as photographs,			room 38 & 35 to meet set		
	paintings, and other	r art, are attached directly to			standards. The Administrator		
	the walls, ceiling, a	and non-fire-rated doors in			verified the removal on 10/25/	2024	
	accordance with the	e following:			2. ALL OTHERS WITH		
	(a) Decorations on	non-fire-rated doors do not			POTENTIAL TO BE AFFECTI	ED:	
	interfere with the o	peration or any required			a. All residents and all staff ar	nd	
	latching of the door	r and do not exceed the area			visitors have the potential to b	e	
	limitations of 18.7.	5.6(b), (c), or (d).			affected but none were. The		
	(b) Decorations do	not exceed 20 percent of the			Maintenance Supervisor/design	gnee	
	wall, ceiling, and de	oor areas inside any room or			conducted an inspection		
	space of a smoke co	ompartment that is not			throughout the facility and fou	nd	
	protected throughou	ut by an approved automatic			no other negative findings.		
		accordance with Section 9.7.			3. MEASURES TO PREVENT		
	(c) Decorations do	not exceed 30 percent of the			REOCCURRENCE:		
	_	oor areas inside any room or			a. On 10/25/2024 the		
	_	ompartment that is protected			Administrator inserviced the		
		pproved supervised automatic			Maintenance Supervisor/designation	gnee	
		accordance with Section 9.7.			and all other staff on the		
	1 1	not exceed 50 percent of the			requirement that door decorat	ions	
		oor areas inside patient			can not exceed 30 percent of	the	
		ing a capacity not exceeding			door to meet set standards.		
	_	moke compartment that is			a Maintenance		
	1 -	ut by an approved, supervised			Supervisor/designee will inspe		
	_	system in accordance with			all areas throughout the facilit	y	
	Section 9.7.				monthly for decorations that		
	-	tice could affect 30 residents,			exceed 30% of the door as a	part	
	staff and visitors in	five smoke compartments.			of the facility's Preventive		
					Maintenance Program and		
	Findings include:				document those inspection re-		
					as appropriate. If any issues		
	Based on observation				discovered, they will be addre		
	Maintenance Direct	tor during a tour of the facility			and resolved immediately. The	ne	

on 10/24/24 from 12:45 p.m. to 3:05 p.m., the

Maintenance Supervisor/designee

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155223	B. W	ING _		10/24/	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t			LIBERTY ST		
WATERS	OF COVINGTON,	THE			GTON, IN 47932		
VVAILING	or obvington,	1116		COVIN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	_	doors had affixed plastic			will review with the Administra	tor	
		sheeting decoration that			the inspection results.		
	covered over 80% o				b The Administrator will		
		lor: the Medical Records office,			monitor adherence to the		
		led Med Room, Skilled Clean			Preventative Maintenance		
		Admissions and Housekeeping			schedule and validate the		
	closet.	in an also Nicona Casa' 1			Preventative Maintenance		
	- in the Freedom Wing: the Nurse Station door, resident room 38 and 35 Based on interview at the time of the				documentation is in place.	<i>-</i>	
					4. MONITORING CORRECTIV	/E	
	Based on interview at the time of the observations, the Maintenance Director agreed				ACTION:		
	observations, the Maintenance Director agreed				a. The inspection results will b		
	the corridor doors were covered with combustible				presented by the Maintenance	;	
	decorations and that the doors were covered over 80%. The Maintenance Director agreed that he				Supervisor/designee to the Administrator monthly and the		
		flame spread rating				:	
	_	the aforementioned door			Administrator will present the inspection results at the month	alv	
	coverings as of the				Quality Assurance/Performand	-	
	coverings as of the	unic of unis survey.			Improvement (QA/PI) meeting		
	This finding was re	viewed with the Administrator			Inspection results and system		
		e Director at the exit			components will be reviewed by		
	conference.	2 2 100tol at the Oat			the QA/PI Committee with	у	
					subsequent plans of correction	n	
	3.1-19(b)				developed and implemented a		
	- ()				deemed necessary to insure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is		
					_11/15/2024.		
K 0914	NFPA 101						
SS=F	Electrical Systems	s - Maintenance and					
Bldg. 01	Testing						
		view and interview, the facility	K 0	914	K914– It is the intent of the fac	-	11/15/2024
		hospital-grade electrical			to ensure all non-hospital grad		
		ent room locations were tested			electrical receptacles at reside		
		FPA 99, Health Care Facilities			room locations are tested at le		
	Code 2012 Edition	Section 6.3.4.1.3 states	1		annually to meet set standards	9	1

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155223	B. W	NG		10/24/	2024
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			LIBERTY ST		
WATERS	S OF COVINGTON,	THE			GTON, IN 47932		
WAILING		, 1111		COVIIN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ed as hospital-grade, at patient			1 CORRECTIVE ACTIONS	3	
		n locations where deep			TAKEN:		
	_	anesthesia is administered,			a On will be completed on	1	
		tervals not exceeding 12			11/12/2024 the Maintenance		
		lly, Section 6.3.3.2, Receptacle			Supervisor completed the more	nthly	
	_	Care Rooms requires the			load bank testing of the		
	physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of				emergency generator which		
					included a full 30 minute test a	and	
		it in each electrical receptacle			documented the results in the		
		Correct polarity of the hot and			facilities Life Safety Binder to		
		s in each electrical receptacle			meet set standards. The		
		and retention force of the			Administrator verified the worl	< will	
		each electrical receptacle			be verified on 11/12/2024		
		be receptacles) shall be not less			b		
		ounces). This deficient practice			2 ALL OTHERS WITH		
	could affect all resi	dents, visitors and staff.			POTENTAL TO BE AFFECTE	:D:	
					a All residents and all staf		
	Findings include:				and visitors have the potential	to	
					be affected but none were.		
		view on 10/24/24 at 12:40 p.m.			3 MEASURES TO PREVE	.NT	
		ice Director, there was no			REOCCURRENCE:		
		ilable for review to indicate all			a On 10/31/2024 the		
		cility's resident rooms had			Administrator inserviced the		
	_	al continuity, polarity and			Maintenance Supervisor/design		
	_	n. Based on interview at the			on the requirement the annua		
		ew, the Maintenance Director			electrical receptacle testing m	ust	
		electrical receptacles in the			be completed annually and		
		e not hospital-grade and there			documented in the life safety		
		ion of annual testing per			binder to meet set standards.		
	_	cle Testing requirements as far			b Maintenance		
		e has been on the job for five			Supervisor/designee will ensu		
	weeks.				the annual electrical receptach	е	
	TT1: C: 1:	1 14 4 4 1 1 1 1			testing is completed and		
		eviewed with the Administrator			documented as a part of the		
	and Maintenance D	Director at the exit conference.			facility's Preventive Maintenar		
	2.1.10(1)				Program and document those		
	3.1-19(b)				inspection results as appropri		
					If any issues are discovered, t	-	
					will be addressed and resolve		
					immediately. The Maintenand	е	

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE C A. BUILDING B. WING	onstruction p	c3) date survey COMPLETED 10/24/2024
	PROVIDER OR SUPPLIE		1600 E	ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST IGTON, IN 47932	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0918	NFPA 101			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 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 11/15/2024.	ce /
SS=F Bldg. 01	Electrical System 1. Based on record facility failed to many of monthly generated.	review and interview, the aintain a complete written record or load testing for 4 of the last er 6.4.4.1.1.4(a) of 2012 NFPA 99	K 0918	K918 – It is the intent of the facility to ensure to maintain a complete written record of mont	11/15/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet

Page 21 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 10/24/2024	
NAME OF P	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP COD	•
WATERS	OF COVINGTON,	THE	COVIN	NGTON, IN 47932	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
		sting of the generator serving		generator load testing for the	last
		trical system to be in		12 months to meet set standa	
		FPA 110, the Standard for ndby Powers Systems, Chapter		1 CORRECTIVE ACTION TAKEN:	S
		4 requires spark-ignited		a. On 10/29/2024 the facilitie	s
		be exercised at least once a		generator contractor conductor	
	month with the avai	lable EPSS load for 30 minutes		the monthly load testing, which	:h
		mperature and the oil pressure		included a 30 minute test, of	the
		apter 6.4.4.2 of NFPA 99		emergency generator and	
	requires a written re	ising period, and repairs for the		documented the results in the	
		ising period, and repairs for the		facilities life safety binder to n set standards. The	neet
	for inspection by th			Administrator verified the wor	k on
		eficient practice could affect all		10/29/2024.	K 611
	occupants.	•		b. On 10/29/2024 the Mainter	nance
				Supervisor completed the we	ekly
	Findings include:			inspection of the emergency	
				generator and documented th	
		view of 'Emergency Generator		results in the facilities Life Sa	
		with the Maintenance 4 between 10:15 a.m. and 12:45		Binder to meet set standards. The Administrator verified the	
		set in service was exercised		10/29/2024	WOIK
		s for four of the last twelve		2 ALL OTHERS WITH	
	months. The genera	tor was ran under load for 10		POTENTIAL TO BE AFFECT	ED:
		e months of February, April,		a All residents and all state	
		2024. Based on interview at		and visitors have the potentia	l to
		eview, the Maintenance		be affected but none were.	ENT
		ad been on the job for five nat the provided monthly test		3 MEASURES TO PREVE	IN I
		nerator did not run for the		a On10/25/2024Th	e e
		s for 4 of the last twelve		Administrator inserviced the	
	months.			Maintenance Supervisor/desi	gnee
				on the requirement to ensure	
	_	viewed with the Administrator		monthly load bank test, which	
	and Maintenance D	irector at the exit conference.		includes a 30 minute test, and	
	2 Daged 1	uoriarrandintami 41		weekly inspections are perfor	
		review and interview, the sure a written record of weekly		on the generator and docume	
	-	emergency generator set was		in the life safety binder to med standards.	51 961
	-	2 weeks from October 2023		b The Maintenance	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155223	B. W	ING		10/24/	2024
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\.\\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\	05.00\#\\0.70\\	T. 15			LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVING	GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN 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*	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	through October 20	24. This deficient practice			Supervisor/designee will ensur	re a	
	could affect all resid	dents, staff and visitors.			monthly load bank test, which		
					includes a 30 minute test, and		
	Findings include:				weekly inspections are perforn	ned	
					on the generator and documer	nted	
	Based on review of	"Weekly Inspection			in the life safety binder as a pa	rt of	
	Checklist" documer	ntation with the Maintenance			the facility's Preventive		
	Director during record review from 10:15 a.m. to				Maintenance Program and		
	12:45 p.m. on 10/24/24, documentation of weekly				document those inspection res	sults	
	emergency generate	or inspections for two weeks in			as appropriate. If any issues	are	
	July 2024 were not	available for review. Based on			discovered, they will be addres	ssed	
	interview at the time	e of record review, the			and resolved immediately. Th	е	
	Maintenance Direct	or stated he had been on the			Maintenance Supervisor/desig	nee	
	job for five weeks a	nd stated that no additional			will review with the Administrate	tor	
	documentation of w	eekly emergency generator			the inspection results.		
	_	aforementioned time frames			c The Administrator will		
	were available for re	eview.			monitor adherence to the		
					Preventative Maintenance		
	1	viewed with the Administrator			schedule and validate the		
	and Maintenance D	irector at the exit conference.			Preventative Maintenance		
					documentation is in place.		
	3.1-19(b)				4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results wi		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	-	
					Quality Assurance/Performand		
					Improvement (QA/PI) meeting	-	
					Inspection results and system		
					components will be reviewed by	у	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	S	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNLH21 Facility ID: 000128

If continuation sheet Page 23 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155223	B. WI	ING		10/24/	/2024
NAME OF B	DOLUBER OR GURRU IER			STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			1600 E	LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVIN	GTON, IN 47932		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		<u> </u>	DATE
					allegation of compliance with all regulatory requirements.	1	
					Our date of compliance is		
					11/15/2024.		
K 0007	NEDA 404						
K 0927 SS=E	NFPA 101	Transfilling Cylinders					
SS−⊑ Bldg. 01	Gas Equipment -	Transfilling Cylinders					
Diag. 01	Based on observation	on and interview, the facility	K 0	927	K927– It is the intent of the fac	cility	11/15/2024
failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are			141	to ensure transfilling of oxyger	•	11/13/2027	
				took place in oxygen transfillin			
		portion of a facility, NFPA 99			rooms that are separated from	-	
	2012 edition 11.5.2.	3.1, Transfilling to liquid			portion of a facility, NFPA 99 2	-	
	oxygen base reservo	oir containers or to liquid			edition 11.5.2.3.1, transfilling t	:0	
	oxygen portable cor	ntainers over 344.74 kPa (50			liquid oxygen base reservoir		
	psi) shall include the				containers or to liquid oxygen		
		ea separated from any portion			portable containers over 344.7	74	
	-	patients are housed,			kPa to meet set standards.		
		d by a fire barrier of 1 hour			1 CORRECTIVE ACTIONS	3	
	fire-resistive constru				TAKEN:		
		nanically ventilated, is			a On 10/25/2024 the		
	-	s ceramic or concrete flooring. ed with signs indicating that			Maintenance Supervisor repai		
	` '	ring and that smoking in the			the oxygen storage/transfer ro		
	immediate area is no	-			52 in the skilled wing, to ensur		
		ransfilling the container(s) has			self closes and latches into the		
	been properly traine	- · · · · · · · · · · · · · · · · · · ·			frame to meet set standards.		
	procedures.	in the transming			Administrator verified the work		
	_	ice could affect up to 10			10/25/2024 .	. 011	
	•	n one smoke compartment.			2 ALL OTHERS WITH		
		•			POTENTAL TO BE AFFECTE	D:	
	Findings include:				a All residents and all staff	f	
					and visitors have the potential	to	
		on with the Maintenance			be affected but none were.		
		4 at 2:55 p.m., the oxygen			3 MEASURES TO PREVE	NT	
	_	m, across the corridor from			REOCCURRENCE:		
		ed wing, contained five liquid			1.On 10/25/2024 the		
	• •	and nine E type oxygen			Administrator inserviced the		
	-	to the oxygen room was			Maintenance Supervisor/desig		
	self-closing, but did	not latch into the door frame			on the requirement to ensure	the	

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLE	
		155223	B. WI	NG	_	10/24/2	024
NAME OF F	DROVIDED OF GUIDNIED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>		1600 E	LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVING	GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nes. Based on interview at the			door to the oxygen		
	I	, the Maintenance Director loor would not latch into the			storage/transfer room self clos	ses	
	frame when self-clo				and latches to meet set standards.		
	maine when sen-cic	ising.			2.Maintenance		
	This finding was re	viewed with the Administrator			Supervisor/DON will ensure th		
	_	irector during the exit			door to the oxygen		
conference.				storage/transfer room self clos	ses		
					and latches as a part of the		
	3.1-19(b)				facility's Maintenance program	,	
	,				and Oxygen Policy and		
					Procedures and document the	se	
					inspection results as appropria	ate.	
					If any issues are discovered, t	hey	
					will be addressed and resolve	d	
					immediately. The Maintenanc	e	
					Supervisor/DON/designee will		
					review with the Administrator t	he	
					inspection results.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w	ill	
					be presented by the		
					DON/designee to the		
					Administrator monthly and the Administrator will present the		
					inspection results at the month		
					Quality Assurance/Performand	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I		
					the QA/PI Committee with	·	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance witl	ո	
					all regulatory requirements.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $MNLH21 \quad \text{Facility ID:} \quad 000128 \qquad \qquad \text{If continuation sheet} \quad \text{Page 25 of 26}$

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/24/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Our date of compliance is11/15/2024.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MNLH21 Facility ID: 000128 If continuation sheet Page 26 of 26