STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155223	A. BUILDING -- B. WING	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/24/24 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 At this Emergency Preparedness survey, The Waters of Covington was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 119 certified beds. At the time of the survey, the census was 82. Quality Review completed on 10/25/24	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: 1. Based on records review of 'Emergency Generator - Monthly Test Log' with the Maintenance Director on 10/24/24 between 10:15	E 0041	**E041**– It is the intent of the facility to ensure to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110 and Life Safety Code in accordance with 42 CFR 483.73 (E) (2) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**:	11/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Foreman	Administartor	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING -- B. WING	10/24/2024

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	a.m. and 12:45 p.m., the generator set in service was exercised less than 30 minutes for four of the last twelve months. The generator was ran under load for 10 to 20 minutes for the months of February, April, July and September 2024. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for five weeks and agreed that the provided monthly test logs showed the generator did not run for the required 30 minutes for 4 of the last twelve months. 2. Based on review of "Weekly Inspection Checklist" documentation with the Maintenance Director during record review from 10:15 a.m. to 12:45 p.m. on 10/24/24, documentation of weekly emergency generator inspections for two weeks in July 2024 were not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for five weeks and stated that no additional documentation of weekly emergency generator inspections for the aforementioned time frames were available for review. These findings were reviewed with the Administrator and Maintenance Director at the exit conference.		a On 10-29-2024 the Maintenance Supervisor completed the monthly load bank testing of the emergency generator which included a full 30 minute test and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work 10-30-2024 b On _10-25-2024 the Maintenance Supervisor completed the weekly inspection of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work 10-30-2024 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/25/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that a monthly 30 minute load bank test and weekly inspection of the emergency generator is required and document the results in the Life Safety Binder to meet set standards. b The Maintenance Supervisor /designee will ensure a monthly 30 minute load bank test and weekly inspection of the emergency	

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			generator is conducted and document the results in the Life Safety Binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a At least every month the load bank testing will be completed and weekly inspection of the generator will be conducted to ensure compliance; the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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_.**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/24/24 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 At this Life Safety Code survey, The Waters of Covington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 82 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for two detached storage sheds and a detached Garage which were not sprinklered. Quality Review completed on 10/25/24	K 0000		

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 69 of 69 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Battery Operated Smoke Detector Maintenance Logs on 10/24/24 from 10:15 a.m. to 12:45 p.m. with the Maintenance Director present, the resident room battery operated smoke alarms were tested on a monthly basis during the past twelve months. Based on observation with the Maintenance Director during a tour of the facility, the battery operated smoke detector located in resident room #25 was a Kidde model i9010 and requires weekly testing. Based on interview at the time of review and observation, the Maintenance Director stated that all battery-operated smoke detectors in the facility are tested monthly and confirmed that manufacturers instructions of the one in resident room #25 called for weekly testing. There was documentation showing that all battery smoke	K 0300	**K300**– It is the intent of the facility to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms is complete to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 10-30-2024 the Maintenance Supervisor/designee performed the weekly testing of the resident room battery operated smoke alarm in all resident rooms including room 25 to meet set standards. The Administrator verified the work on 10-31-2024 **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/31/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure all battery operated smoke alarms are maintained and tested per manufactures guidelines to meet set standards. b Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained and tested per manufactures guidelines (weekly) and will document the results on	11/15/2024

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	detectors were replaced October 2023. The Maintenance Director stated he would start performing testing as required by manufacture's instruction. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(c)		the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024____.**	

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K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as Laundries (larger than 100 square feet in size) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect staff in the vicinity of the Laundry Room in the service hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:05 p.m. on 10/24/24, the corridor door to the Laundry Room in the service hall wing of the facility was propped open. The corridor door to the Laundry Room was equipped with a self closing device and latching hardware to latch the door into the door frame but was propped open with a wooden wedge placed on the floor. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and door with the door being propped open. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	**K321**– It is the intent of the facility to ensure hazardous areas such as laundries are separated from other spaces by smoke resistant partitions and doors to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/25/2024 the Maintenance Supervisor/designee removed the wooden wedge from the corridor door to the laundry room to meet set standards. The Administrator verified the work on 10/25/2024 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/25/2024 the Administrator inserviced the Maintenance Supervisor/all laundry and housekeeping staff/all other staff on the requirement to ensure hazardous areas are equipped with a self-closing door 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 they	11/15/2024

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			self-close, shut and latch and ensure doors are not propped open 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. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Fountain Wing smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/24/24 during a tour of the facility from 12:45 p.m. to 3:05 p.m., the clean linen room by the Fountain Wing nurse station had a missing escutcheon. There was a 1/2 inch gap that exposed the attic space. Additionally, the sprinkler in housekeeping storage room by Therapy had a missing escutcheon. Based on interview at the time of observations, the Maintenance Director confirmed the escutcheons were missing in each location. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0351	**11/15/2024** **K351** - It is the intent of the facility to 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/designee installed the escutcheon rings in the clean linen room by the fountain wing nurses station and in the housekeeping storage room by therapy to meet set standards. The Administrator verified the work on 11/11/2024 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/31/2024 _____ the Administrator in serviced the Maintenance Supervisor/designee to ensure to maintain ceiling construction including the sprinkler head escutcheon rings to meet set standards. b Maintenance Supervisor/designee will ensure to	11/15/2024

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			maintain ceiling construction including the sprinkler head escutcheon rings 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. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers 1. Based on observation and interview, the facility failed to maintain 1 of 1 portable K Class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 2:05 p.m. on 10/24/24, a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director confirmed a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.	K 0355	**11/15/2024.** **K355**– It is the intent of the facility to ensure to maintain portable K class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10 and to ensure portable fire extinguishers are installed in accordance with NFPA 10 to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 11/11/2024 the Administrator/Maintenance Supervisor/designee installed a placard by the portable K class fire extinguisher in the kitchen stating the fire protection system shall be activated prior to using the fire extinguisher to meet set standards. The Administrator verified the relocation on 11/11/2024 _____ . b On 11/11/2024 the Maintenance Supervisor/designee relocated the K class fire extinguisher located in the kitchen so it is mounted with the top of the extinguisher no greater than five feet above the floor when measured to meet set standards. The Administrator verified the relocation on 11//11/2024 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff	11/15/2024

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	2. Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 5 staff and visitors in the kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 2:05 p.m. on 10/24/24, the portable K Class fire extinguisher located in the kitchen was mounted on the wall with the top of the extinguisher 5 feet 8 inches above the floor. Based on interview at the time of observation, the Maintenance Director confirmed K Class extinguisher was mounted with the top of the extinguisher greater than five feet above the floor when measured. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10/31/2024 the Administrator inserviced the Maintenance Supervisor/and all dietary staff on the requirement that portable fire extinguishers must have placards stating the fire protection system shall be activated prior to using the fire extinguisher and must not be installed higher than 5 feet from floor when measured to meet set standards. b Maintenance Supervisor/designee will ensure portable fire extinguishers have placards stating the fire protection system shall be activated prior to using the fire extinguisher and must not be installed higher than 5 feet from floor when measured 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. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4 MONITORING CORRECTIVE ACTION: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 10 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 18 residents, as well as 4 staff and 2 visitors.	K 0374	**K374** – It is the intent of the facility to ensure sets of barrier doors would restrict the movement of smoke for at least 20 minutes to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11/11/2024 the Maintenance Supervisor/designee repaired the barrier door set by medical records to ensure it closes fully to meet set standards. The Administrator	11/15/2024

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	Findings include: Based on observations made on 10/24/24 during a tour of the facility at 1:55 p.m. with the Maintenance Director, the barrier door set by Medical Records failed to fully close smoke tight leaving an eight-inch gap when closed to their fullest. Based an interview at the time of observation, the Maintenance Director confirmed that the coordinator at the door set did not function properly when the doors were tested and they did not close completely. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		verified the repairs on _11/11/2024___ . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 11/8/2024 the Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/31/2024 the Administrator in serviced the Maintenance Supervisor/designee and all staff the requirement that smoke barrier doors must resist fire for 20 minutes and have no penetrations to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they are maintained and have a 20-minute fire rating as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report"	K 0712	**K712** –It is the intent of the facility to ensure to conduct fire drills for 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	11/15/2024

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	forms with the Maintenance Director on 10/24/24 at 10:33 a.m., there was no documentation for a third shift fire drill in the first quarter (January, February, or March) of 2024. There was a day shift and two evening shift fire drills conducted on the first quarter. Based on interview at the time of record review, the Maintenance Director stated he has been on the job for five weeks and that there are not any additional fire drills available for review at the time of this survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		including for the third shift and documented the information in the facilities life safety binder to meet set standards. On will be verified on 11/12/2024 the Administrator confirmed the drill. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On _10/31/2024_ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure fire drills are conducted quarterly, on each shift, under varying conditions to meet set standards. b 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. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.**	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 10 of over 50 corridor doors contain decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of	K 0753	**K753**– It is the intent of the facility to ensure corridor doors contain decorations that did not exceed 30 percent of the door to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 10/25/2024 the Maintenance Supervisor/designee removed the plastic Halloween themed sheeting decorations from the	11/15/2024

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	NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 30 residents, staff and visitors in five smoke compartments. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 10/24/24 from 12:45 p.m. to 3:05 p.m., the		following locations: 1. In the center corridor: Medical records office, housekeeping, skilled med room, skilled clean linen, classroom, admissions and housekeeping closet and 2. In the freedom wing: the nurse station door, resident room 38 & 35 to meet set standards. The Administrator verified the removal on 10/25/2024 **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee conducted an inspection throughout the facility and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 10/25/2024 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that door decorations can not exceed 30 percent of the door to meet set standards. a Maintenance Supervisor/designee will inspect all areas throughout the facility monthly for decorations that exceed 30% of the door as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee	

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	following corridor doors had affixed plastic Halloween themed sheeting decoration that covered over 80% of the doors: -in the center corridor: the Medical Records office, Housekeeping, Skilled Med Room, Skilled Clean Linen, Classroom, Admissions and Housekeeping closet. - in the Freedom Wing: the Nurse Station door, resident room 38 and 35 Based on interview at the time of the observations, the Maintenance Director agreed the corridor doors were covered with combustible decorations and that the doors were covered over 80%. The Maintenance Director agreed that he could not provide a flame spread rating documentation for the aforementioned door coverings as of the time of this survey. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		will review with the Administrator the inspection results. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure 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.**	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review and interview, the facility failed to ensure nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states	K 0914	**K914**– It is the intent of the facility to ensure all non-hospital grade electrical receptacles at resident room locations are tested at least annually to meet set standards.	11/15/2024

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	receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents, visitors and staff. Findings include: Based on record review on 10/24/24 at 12:40 p.m. with the Maintenance Director, there was no documentation available for review to indicate all the outlets in the facility's resident rooms had undergone an annual continuity, polarity and retention inspection. Based on interview at the time of record review, the Maintenance Director indicated all of the electrical receptacles in the resident rooms were not hospital-grade and there was no documentation of annual testing per NFPA 99, Receptacle Testing requirements as far as he knew since he has been on the job for five weeks. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		1 **CORRECTIVE ACTIONS TAKEN**: a On will be completed on 11/12/2024 the Maintenance Supervisor completed the monthly load bank testing of the emergency generator which included a full 30 minute test and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work will be verified on 11/12/2024._____ b 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/31/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement the annual electrical receptacle testing must be completed annually and documented in the life safety binder to meet set standards. b Maintenance Supervisor/designee will ensure the annual electrical receptacle testing is completed and documented as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance	

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			Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____11/15/2024.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 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 monthly	11/15/2024

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	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. NFPA 110 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabalized. 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 occupants. Findings include: Based on records review of 'Emergency Generator - Monthly Test Log' with the Maintenance Director on 10/24/24 between 10:15 a.m. and 12:45 p.m., the generator set in service was exercised less than 30 minutes for four of the last twelve months. The generator was ran under load for 10 to 20 minutes for the months of February, April, July and September 2024. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for five weeks and agreed that the provided monthly test logs showed the generator did not run for the required 30 minutes for 4 of the last twelve months. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for all 52 weeks from October 2023		generator load testing for the last 12 months to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a. On 10/29/2024 the facilities generator contractor conducted the monthly load testing, which included a 30 minute test, of the emergency generator and documented the results in the facilities life safety binder to meet set standards. The Administrator verified the work on 10/29/2024. b. On 10/29/2024 the Maintenance Supervisor completed the weekly inspection of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work __10/29/2024 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On ___10/25/2024__The Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure a monthly load bank test, which includes a 30 minute test, and weekly inspections are performed on the generator and documented in the life safety binder to meet set standards. b The Maintenance	

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	through October 2024. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Inspection Checklist" documentation with the Maintenance Director during record review from 10:15 a.m. to 12:45 p.m. on 10/24/24, documentation of weekly emergency generator inspections for two weeks in July 2024 were not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for five weeks and stated that no additional documentation of weekly emergency generator inspections for the aforementioned time frames were available for review. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Supervisor/designee will ensure a monthly load bank test, which includes a 30 minute test, and weekly inspections are performed on the generator and documented in the life safety binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible**	

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			allegation of compliance with all regulatory requirements. Our date of compliance is 11/15/2024.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 10 residents and staff in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/24/24 at 2:55 p.m., the oxygen storage/transfer room, across the corridor from room 52 in the skilled wing, contained five liquid oxygen containers and nine E type oxygen cylinders. The door to the oxygen room was self-closing, but did not latch into the door frame	K 0927	**K927**– It is the intent of the facility to ensure transfilling of oxygen took place in oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/25/2024 the Maintenance Supervisor repaired the oxygen storage/transfer room door across the corridor from room 52 in the skilled wing, to ensure it self closes and latches into the frame to meet set standards. The Administrator verified the work on ___10/25/2024 . 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: 1.On 10/25/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the	11/15/2024

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	when tested five times. Based on interview at the time of observation, the Maintenance Director confirmed that the door would not latch into the frame when self-closing. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		door to the oxygen storage/transfer room self closes and latches to meet set standards. 2.Maintenance Supervisor/DON will ensure the door to the oxygen storage/transfer room self closes and latches as a part of the facility's Maintenance program and Oxygen Policy and Procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/DON/designee will review with the Administrator the inspection results. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the DON/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 01 B. WING	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

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			Our date of compliance is ___11/15/2024.	