CENTERS FOR	R MEDICARE & MEDIC.	_	OMB NO. 0938-039					
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLI	ETED		
		155770	B. WING		07/11/2			
		130.10			3.,,,,,	- ·		
NAME OF D	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD				
TWINE OF F	RO (IDER OR BUITEIEN		1002 SISTER BARBARA WAY					
WATERS	OF GEORGETOW	/N, THE	GEOR	GETOWN, IN 47122				
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	ID		1	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
	`			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			
TAG	KEGULATUKY OR	LSC IDENTIFYING INFORMATION	TAG	DETERMINE!		DATE		
E 0000								
B. I								
Bldg								
		paredness Survey was	E 0000	Preparation and/or execution	າ			
		diana Department of Health in		of this plan of correction in				
	accordance with 42	CFR 483.73.		general, or this corrective				
				action in particular does not				
	Survey Dates: 07/1	0/24 and 07/11/24		constitute and admission or				
	-			agreement by this facility of	the			
	Facility Number: 0	11509		facts alleged, or conclusions				
	Provider Number:			set forth in this statement of				
	AIM Number: 2009			deficiencies. The plan of				
	200.			correction and specific				
	At this Emergency	Preparedness survey, The		corrective actions are prepar	rod			
		wn was found in compliance		1				
		•		and/or executed in complian	ce			
		eparedness Requirements for		with state and federal laws. This plan of correction				
		caid Participating Providers						
	and Suppliers, 42 C	FK 483./3		constitutes our credible				
				allegation of compliance with	n			
		certified beds, with a current		all regulatory requirements.				
	census of 61.			Our date of compliance is				
				August 16, 2024. This provid				
	Quality Review con	npleted on 07/16/24		respectfully requests that the	is			
				2567 Plan of Correction be				
				considered the Letter of				
				Credible Allegation of				
				Compliance and requests a				
				desk review in lieu of a post				
				survey revisit.				
K 0000								
Bldg. 01								
g. 0 i	A Life Safety Code	Recertification and State	K 0000	Preparation and/or execution	,			
	-	as conducted by the Indiana	IX 0000	of this plan of correction in	•			
	•	th in accordance with 42 CFR		general, or this corrective				
	-	m in accordance with 42 CFR		1 -				
	483.90(a).			action in particular does not				
	a D: 05/4	0/24 1 07/11/24		constitute and admission or				
	Survey Dates: 07/1	U/24 and U //11/24		agreement by this facility of				
				facts alleged, or conclusions	•			
			1					

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

TITLE

(X6) DATE

Eric Will Administrator 08/01/2024

Any defiency statement 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 disclodays 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: OZM221 Facility ID: 011509 If continuation sheet Page 1 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155770	B. W	ING		07/11/	/2024
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			STER BARBARA WAY		
\\\\\\TED\$	OF GEORGETOW	/N THE			GETOWN, IN 47122		
WAIERS	OF GEORGETON	VIN, IIIE		GEURU	JL I OVVIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Facility Number: 0				set forth in this statement of		
	Provider Number:	155770			deficiencies. The plan of		
	AIM Number: 2009	909280			correction and specific		
					corrective actions are prepar	red	
	-	Code survey, The Waters of			and/or executed in complian	ce	
		ound not in compliance with			with state and federal laws.		
	Requirements for P	articipation in			This plan of correction		
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			constitutes our credible		
	Life Safety from Fi	re and the 2012 edition of the			allegation of compliance with	h	
	National Fire Protect	ction Association (NFPA) 101,			all regulatory requirements.		
		SC), and 410 IAC 16.2. Villa			Our date of compliance is		
	1002 was surveyed	with Chapter 19, Existing			August 16, 2024. This provid	der	
	Health Care Occupa	ancies.			respectfully requests that th	is	
					2567 Plan of Correction be		
	This one story facil:	ity was determined to be of			considered the Letter of		
	Type V (111) const	ruction and fully sprinkled.			Credible Allegation of		
	The facility has a fir	re alarm system with smoke			Compliance and requests a		
	detection in the corr	ridors, spaces open to the			desk review in lieu of a post		
	corridors, and all re	sident sleeping rooms. The			survey revisit.		
		ty of 10 and had a census of					
	10 at the time of thi	s visit.					
		idents have customary access					
	•	all areas providing facility					
	services were sprinl	kled.					
	Quality Review con	mpleted on 07/16/24					
K 0345	NEDA 101						
SS=F	NFPA 101	. Tooting and					
Bldg. 01	Fire Alarm System	ı - resung and					
Diay. UT	Maintenance	Tooting and					
	Fire Alarm System Maintenance	ı - resung and					
		m is tosted and maintained					
		m is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
	-	n acceptance, maintenance					
	and testing are rea	adiiy avallable.	1				I

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION 04	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155770	B. W	JILDING ING	01	COMPI 07/11	
		100770	В. ,,	_		07711	7202-
NAME OF I	PROVIDER OR SUPPLIER	8		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY			
\\\\\		VALITATE					
WATERS	S OF GEORGETOV	VIN, THE		GEURG	GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		FPA 70, NFPA 72					
		review and interview, the	K 0	345	K345 – Building 8 - It is the		08/16/2024
	_	sure the annual testing of all			intent of the facility to ensure	the	
		to 1 of 1 fire alarm system was			annual testing of all devices		
	_	72, National Fire Alarm Code,			connected to fire alarm system		
		t 14.6.2.4 requires a record of all			are performed and to maintai		
		, and maintenance shall be			alarm system in accordance		
		les the following information			NFPA 72, as required by LSC		
		all the applicable information			Sections 19.3.4.5.1 and 9.6 a		
	requested in Figure (1) Date	14.0.2.4:			ensure complete documentat		
	(2) Test frequency				available for the sensitivity tends of all hard wired smoke detection	-	
	(3) Name of proper	fr			and to show what testing	iois	
	(4) Address	ry			instrument is used to test all		
	* /	performing inspection,			smoke detectors for sensitivit	v to	
		or combination thereof, and			meet set standards.	y to	
		address, and telephone			1 CORRECTIVE ACTION	S	
	number	auditoss, und toropriorio			TAKEN:	•	
		and representative of			a On 8/9/2024 the facilitie	s	
	approving agency (-			licensed contractor performed		
		the detector(s) tested			annual fire alarm system		
	(8) Functional test of				inspection / test report and		
	· ·	of required sequence of			documented in the facilities L	ife	
	operations	•			Safety Binder to meet set		
	(10) Check of all sn	noke detectors			standards. The Administrator	-	
	(11) Loop resistanc	e for all fixed-temperature,			verified the work on 8/9/2024		
	line-type heat detec	tors			b On 8/9/2024 the facilitie	S	
	(12) Functional test	of mass notification system			licensed contractor performed	the	
	control units				semi-annual visual fire alarm		
	(13) Functional test	of signal transmission to mass			system inspection and		
	notification systems				documented in the facilities L	ife	
	1 1	of ability of mass notification			Safety Binder to meet set		
	_ ·	re alarm notification appliances			standards. The Administrator		
		gibility of mass notification			verified the work on 8/9/2024		
	system speakers				c On 8/9/2024 the facilitie	s	
		required by the equipment			license contractor performed		
	manufacturer's publ				biannual sensitivity testing on	the	
	(17) Other tests as r	required by the authority			fire alarm system smoke		

having jurisdiction

(18) Signatures of tester and approved authority

detectors and documented the

results in the Life Safety Binder

INDITIES THE ADDRESS. CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE INDITIES OF GEORGETOWN, THE THE CONTROL OF THE COORDINATION OF	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
STREET ADDRESS. CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, THE SUMMARY STATEMENT OF DEFICIENCIE (IACAT DEFICIENCY MIST HE PRECEDED BY PULL ATTACK SECURITY OF A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE OF THE PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPLETION DATE. THE PRESTANCE OF THE PRECEDED BY PULL PROPERTY AND A COMPL	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
WATERS OF GEORGTOWN, THE WATERS OF GEORGTOWN, THE SIMMARY STATEMENT OF DEFICIENCE (PACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX			155770	B. W	ING		07/11/	2024
WATERS OF GEORGTOWN, THE WATERS OF GEORGTOWN, THE SIMMARY STATEMENT OF DEFICIENCE (PACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG And Also documented the manufacture's calibrated sensitivity test instrument from the fire alarm system inspection contractor to meet set standards. The Administrator verified the work on 8/9/2024. A LI 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 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm system in spections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument trom the fire alarm system in spection contractors contractor to meet set standards. The Administrator verified the work on 8/9/2024. A LI 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 REOCCURENCE: A On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual a			<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122	NAME OF P	PROVIDER OR SUPPLIER	8					
ID PROFITE TAG PROPERTY ACTION SHEET PRICE PROFITE TAG PROFITE PRICE PROFITE PRICE PROFITE PRICE PROFITE PRICE PROFITE PRICE P	WATERS	OF GEORGETOW	VN, THE					
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION representative (19) Disposition of problems identified during test (c.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/lest report performed during the past 12 month period. The most recent annual fire alarm system inspection/lest report vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the action from the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that the following more often if required by the authority having jurisdiction. Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1, states that the following must be visually inspected semi-annually:				1	ID			(Y5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system in systemiony report performed during the past 12 month period. The most recent annual fire alarm system in spection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1, tattes that the following must be visually inspected semi-annually:						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection of visitors have the potential to be affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the work on 8/9/2024. 8 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm system are maintained properly including the semi-annual and annual fire alarm system inspections and at-30 p.m. with the Director of Nursing and Maintenance Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1, states that the following must be visually inspected semi-annually:		`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
(19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility fire lalarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: manufacturer's calibrated sensitivity test instrument from the fire alarm system inspection contractor to meet set standards. The Administrator verified the work on 8/9/2024. 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 8/6/2024 the Administrator or serviced the Administrator or serviced the Administrator or serviced the vork on 8/9/2024. 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 8/6/2024 the Administrator neared and annual fire alarm system i	IAG		CESC IDENTIFY ING INFORMATION		IAG	and also documented the		DATE
(e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72 72, ser required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, ser required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NPA 72, as required by		•	problems identified during test					
corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1, states that the following must be visually inspected semi-annually:			-				the	
abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system were. This finding was reviewed with the Director of review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 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 8/6/2024 the Administrator verified the work on 8/9/2024. 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 8/6/2024 the Administrator verified the work on 8/9/2024. 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 8/6/2024 the Administrator verified the work on 8/9/2024. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator verified the work on 8/9/2024. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator verified the work on 8/9/2024 the Administrator verified the work on 8/9/2024. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator verified the work on 8/9/2024 the Administrator verified the work on 8/9/2024 the Administrator verified the work on 8/9/2024.			-			1	i ti iC	
This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system in approach of Nursing and Maintenance Director of Nursing and Maintenance Director during the past 12 month period. The most recent annual fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by the sending jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: The Administrator verified the work on 8/9/2024. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a All residents and all staff and visitors were the potential to be affected but none were. 3 MEASURES TO PREVENT RECCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:						•	de	
in the facility. Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: on 8/9/2024. 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 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to lease affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections shafted by the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly		- '						
Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: 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 RECCCURRENCE: a On 8/6/2024 the Admintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		-	ice could affect all occupants				WOIK	
Findings include: Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: POTENTIAL TO BE AFFECTED: a All residents and all staff and visiton have the potential to be affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		in the facility.						
Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system in inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a All residents and all staff and visitors have the potential to be affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to mesure set standards. b Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing to a fire alarm system on the requirement to sensitivity test alarm system serviced the Maintenance Supervisor/designee on the requirement to ensure fre alarm systems are ma		Findings include:					:D·	
Based on record review on 07/10/24 between 10:15 a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. The facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: and visitors have the potential to be affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facility failed to maintain 1 of 1 fire alarm system in accordance with the Sendeules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:		i manigs merade.						
a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: be affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm system in spections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee on the requirement to ensure fire alarm system inspections and testing documents to be retained in the facilities Life safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectorse		Based on record rev	view on 07/10/24 between 10:15					
present, the facility was unable to provide an annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: 3 MEASURES TO PREVENT REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm system in spections and testing documents to be retained in the facilities Life Safety Binder and to						•	to	
annual fire alarm system inspection/test report performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1, states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: REOCCURRENCE: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the fire alarm system inspections and testing documents to be retained in the fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		•					NT	
performed during the past 12 month period. The most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems inspections and testing documents to be retained in the facilities Life Safety Binder and to							141	
most recent annual fire alarm system inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by inspected semi-annual and annual fire alarm system in spections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee on the requirement to ensure fire alarm system in spections and testing documents to be retained in the facilities Life Safety Binder and to								
inspection/test report was dated 06/14/23 performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to								
performed by the facility's fire alarm system vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if requirement to ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system in alarm systems are maintained properly including the semi-annual instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to							ınaa	
vendor. Based on interview at the time of record review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to						-		
review, this was confirmed by the Maintenance Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the Maintenance must be visually inspected semi-annually: properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to						•		
Director. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to						-		
inspections and testing documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:			infilled by the Maintenance			1	iiuai	
This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: documents to be retained in the facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		Birector.				_		
Nursing and Maintenance Director during the exit conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: facilities Life Safety Binder and to ensure the smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		This finding was re	viewed with the Director of			_	ne.	
conference on 07/11/24. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: ensure the smoke detector sensitivity test of all hard wired smoke detector sensitivity test of all hard wired smoke detector sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to								
sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired smoke detectors contains the name of the manufacturer's calibrated sensitivity test of all hard wired sensitivity test of all hard sensitivity test of all hards		~	e e			<u> </u>	u 10	
3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: smoke detectors contains the name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to							4	
name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: name of the manufacturer's calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		3.1-19(b)					4	
2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: calibrated sensitivity test instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		(-)						
facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: instrument to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		Based on record	review and interview, the					
accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: b Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to							rds.	
Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: Supervisor/designee will ensure fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to		_	•					
14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: fire alarm systems are maintained properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to							re	
14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: properly including the semi-annual and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to								
accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: and annual fire alarm system inspections and testing documents to be retained in the facilities Life Safety Binder and to						-		
more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: inspections and testing documents to be retained in the facilities Life Safety Binder and to		-	-					
jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: documents to be retained in the facilities Life Safety Binder and to		· ·				_		
must be visually inspected semi-annually: facilities Life Safety Binder and to		•	,			1 '	ne	
		-						
a. Control unit trouble signats I ensure the smoke detector		a. Control unit troul	-			ensure the smoke detector		
b. Remote annunciators sensitivity test of all hard wired			_				t	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155770	B. W	ING		07/11/2	2024
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF I	PROVIDER OR SUPPLIEF	8			STER BARBARA WAY		
\\/\TED	S OF GEODGETON	VN THE			GETOWN, IN 47122		
WAIERS	OF GEORGETOV	VIN, IIIE		GEORG	JL 1 OVVIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		(e.g. duct detectors, manual			smoke detectors contains the		
		eat detectors, smoke detectors,			name of the manufacturer's		
	etc.)				calibrated sensitivity test		
	d. Notification appliances				instrument as a part of the		
	e. Magnetic hold-op				facility's Preventive Maintenar		
	_	ice could affect all residents,			Program and document those		
	staff, and visitors in	the facility.			inspection results as appropria		
			1		If any issues are discovered, t	-	
	Findings include:				will be addressed and resolve		
					immediately. The Maintenand		
		view on 07/10/24 between 10:15			Supervisor/designee will revie	W	
	•	with the Maintenance Director			with the Administrator the		
	_	no documentation provided			inspection results.		
		nnual visual fire alarm system			c The Administrator will		
		ne past 12 month period. The			monitor adherence to the		
		em inspection/test provided			Preventative Maintenance		
		for an annual fire alarm			schedule and validate the		
		ne facility's vendor. Based on			Preventative Maintenance		
		e of record review, the			documentation is in place.		
		tor confirmed there was no			4 MONITORING		
		inspection of the facility's fire			CORRECTIVE ACTION:		
		es performed during the past			a The inspection results w	I	
	12 month period.				be presented by the Maintena	nce	
					Supervisor/designee to the		
	_	viewed with the Director of	1		Administrator and the		
	_	enance Director during the exit			Administrator will present the		
	conference on 07/1	1/24.			inspection results at the month	· .	
	2.1.10(1-)				Quality Assurance/Performan	I	
	3.1-19(b)				Improvement (QA/PI) meeting		
	2 Daged 1	novious and intermises. 41-			Inspection results and system		
		review and interview, the			components will be reviewed I	by	
		sure complete documentation e sensitivity testing of all hard			the QA/PI Committee with		
		ors, and to show what testing			subsequent plans of correction	I	
		ors, and to snow what testing d to test all smoke detectors			developed and implemented a	is	
					deemed necessary to ensure		
	for sensitivity. NFPA 72, National Fire Alarm				compliance is maintained.		
	Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year				This plan of correction		
		_			constitutes our credible	<u> </u>	
		every alternate year thereafter.			allegation of compliance with	n	
	After the second rec	quired calibration test, if	1		all regulatory requirements.		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		UILDING	onstruction 01	(X3) DATE COMPL 07/11/	ETED
	PROVIDER OR SUPPLIER S OF GEORGETOV		•	1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	•	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	sensitivity tests indiremained within its range, the length of shall be permitted to 5 years. If the frequence detector caused nuitrends of these alarmatores over the properties of these alarmatores over the properties of the performed. It is that the control of the purpose. (4) Smoke detector arrangement where at the control unit with its listed sensitivity (5) Other calibrated to the authority have Detectors found to listed and marked seleaned and recalibe The detector. This deficit residents, staff, and Findings include: Based on record revalunce as show a smoke detector smoke detector. The was desired to the wired smoke detector.	icate that the detector has listed and marked sensitivity time between calibration tests to be extended to a maximum of tency is extended, records of sance alarms and subsequent ms shall be maintained. In the nuisance alarms show an revious year, calibration tests To ensure that each smoke is listed and marked sensitivity sted using any of the methods: method. Calibrated sensitivity test quipment arranged for the If fire alarm control unit they the detector causes a signal where its sensitivity is outside range. It sensitivity method acceptable ing jurisdiction. The sensitivity range shall be rated, or replaced. Vity cannot be tested or a spray device that administers centration of aerosol into the citent practice could affect all visitors in the facility. View on 07/10/24 between 10:15 with the Maintenance Director locumentation available to cotor sensitivity test of all hard ors was performed on 06/14/23		TAG	Our date of compliance is 8/16/2024.	ME.	DATE
	by the facility's fire	alarm system inspection					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 6 of 135

		X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155770	B. Wl	ING		07/11/	2024
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWINED'S BLANGE 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'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	name of the manufa test instrument. Thi Maintenance Direct This finding was rev	e report did not include the cturer's calibrated sensitivity is was confirmed by the or at the time of record review. viewed with the Director of mance Director during the exit					
	2.1 17(0)						
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system	supply source					
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to proother evidence the shad been inspected for 1 of 1 sprinkler any device, equipme compliance with thi	-	K 0	353	K353 – Building 08 It is the intof the facility to ensure to provwritten documentation or other evidence the sprinkler system components have been inspectand tested for 1 of 4 quarters for the sprinkler system and to ensure to document sprinkler	ide - cted	08/16/2024

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 7 of 135

PRINTED: 08/02/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155770	B. WING		07/11/2024
			CTREET	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		SISTER BARBARA WAY	
\MATER9	S OF GEORGETOV	VN THE		RGETOWN, IN 47122	
WAILING	O GEORGETOV	VIN, III			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		shall be properly maintained in		system inspections in accorda	
		FPA 25, Standard for the		with NFPA 25 the dry sprinkle	· · · · · · · · · · · · · · · · · · ·
		, and Maintenance of		system's pressure gauges an	· · · · · · · · · · · · · · · · · · ·
		Protection Systems. NFPA 25,		during 10 of the past 12 mont	
	_	ds shall be made for all		for the sprinkler system's conf	
	_	nd maintenance of the system		valves to meet set standards.	
	_	all be made available to the		1.CORRECTIVE ACTIONS	
		risdiction upon request. 4.3.2		TAKEN:	
	*	s shall indicate the procedure		1.On 8/9/2024 the facilities	es
		spection, test, or maintenance),		licensed sprinkler contractor	
	_	at performed the work, the		performed the quarterly sprink	
		e. NFPA 25, 5.2.5 requires that		inspection and documented th	· · · · · · · · · · · · · · · · · · ·
		evices shall be inspected		results in the facilities Life Sat	, I
		they are free of physical		Binder to meet set standards.	
	_	, 5.3.3.1 requires the mechanical		The Administrator verified the	work
		evices including, but not limited		on 8/9/2024.	
	_	ngs, shall be tested quarterly.		2.On 7/31/2024 the	
	_	ne-type and pressure		Maintenance Supervisor perfo	ormed
		ow alarm devices shall be		the weekly inspection of the	
		7. This deficient practice could		facilities dry sprinkler system	
		staff, and visitors in the		gauges and documented the	
	facility.			results in the facility life safety	
				binder to meet set standards.	
	Findings include:			Administrator verified the worl	k on
				7/31/2024.	
		the quarterly sprinkler system		3.On 7/31/2024 the	
	_	on 07/10/24 between 10:15 a.m.		Maintenance Supervisor perfo	ormed
	_	the Maintenance Director		the monthly inspection of the	
	_	no quarterly sprinkler system		facilities sprinkler system conf	· · · · · · · · · · · · · · · · · · ·
		vailable for the second quarter		valves and documented the re	
		nne) of 2024. Based on		in the facility life safety binder	to
		e of record review, the		meet set standards. The	
		tor confirmed there was no		Administrator verified the worl	k on
		ion available to show the		7/31/2024 .	
		d been inspected during the		2.ALL OTHERS WITH	
	second quarter of 2	024.		POTENTIAL TO BE AFFECT	
	1		1	1.All residents and all sta	att I

conference on 07/11/24.

This finding was reviewed with the Director of

Nursing and Maintenance Director during the exit

and visitors have the potential to

3.MEASURES TO PREVENT

be affected but none were.

PRINTED: 08/02/2024

	T OF HEALTH AND HU! R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY	
WATER	S OF GEORGETOV	VN, THE		GETOWN, IN 47122	
(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 APPROPRI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	3.1-19(b) 2. Based on record interview; the facilis system inspections for 1 of 1 dry sprint past 52 weeks for the gauges, and during the sprinkler system Standard for the Insection Maintenance of Was Systems, 2011 Edit gauges on dry pipe inspected weekly to water pressures are 5.1.2 states valves a connections shall be maintained in accord Section 13.1.1.2 stautilized for inspectivalves, valve compostates records shall tests, and maintenance components and shauthority having juring deficient practice of and visitors in the face of the same proposed in t	review, observation, and ty failed to document sprinkler in accordance with NFPA 25 kler system during 47 of the ne sprinkler system's pressure 10 of the past 12 months for n's control valves. NFPA 25, spection, Testing, and ster-Based Fire Protection ion, Section 5.2.4.2 states sprinkler systems shall be to ensure that normal air and being maintained. Section and fire department the inspected, tested, and redance with Chapter 13. test Table 13.1.1.2 shall be on, testing and maintenance of conents and trim. Section 4.3.1 be made for all inspections, nice of the system and its hall be made available to the risdiction upon request. This could affect all residents, staff, facility.	TAG	REOCCURRENCE: 1.On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/desi on the requirement to ensure sprinkler inspections are conducted and documented including the quarterly sprinkl inspection, weekly inspection the gauges and the monthly inspection of the control valve meet set standards. 2.Maintenance Supervisor/designee will ensu sprinkler inspections are conducted and documented including the quarterly sprinkl inspection, weekly inspection the gauges and the monthly inspection, weekly inspection the gauges and the monthly inspection of the control valve a part of the facility's Prevent Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. To Maintenance Supervisor/desi will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	ignee ler of es to ure ler of es as ive esults s are essed he ignee
	_	ere was no documentation ne facility's dry sprinkler		Preventative Maintenance documentation is in place.	
		e inspected weekly during 47		4.MONITORING CORRECT	rive
		period. The only weekly		ACTION:	

sprinkler gauge inspections were for the weeks in

June and July of 2024. Based on interview at the

time of record review, the Maintenance Director

OZM221

1.The inspection results will

be presented by the Maintenance

Supervisor/designee to the

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155770	B. W	ING		07/11/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				STER BARBARA WAY		
\M/ATEDS	OF GEORGETOW	/N THE			GETOWN, IN 47122		
WATERS	OF GEORGETON	/N, 111E		GEORG	3E1 OWN, IN 47 122		
(X4) ID	SUMMARY S	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 APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. –	DATE
	confirmed there was	s no documentation available			Administrator monthly and the		
	to show that the faci	ility's sprinkler gauges have			Administrator will present the		
	been inspected at lea	ast weekly during 47 of the			inspection results at the month	ıly	
	past 52 weeks. Based on observations on				Quality Assurance/Performand	e	
	07/11/24 between 9	:45 a.m. and 12:15 p.m. during a			Improvement (QA/PI) meeting		
	tour of the facility w	vith the Maintenance Director			Inspection results and system		
	the facility had two	pressure gauges at the			components will be reviewed by	у	
	sprinkler riser.				the QA/PI Committee with		
					subsequent plans of correctior	1	
	b. Based on record	review on 07/10/24 between			developed and implemented a	s	
	10:15 a.m. and 4:30	p.m. with the Maintenance			deemed necessary to ensure		
	Director present, the	ere was no monthly sprinkler			compliance is maintained.		
	system control valve	es inspection documentation			This plan of correction		
	for 10 of the past 12	2 months. The only monthly			constitutes our credible		
	inspections available	e were for June and July of			allegation of compliance with	1	
	2024. Based on inte	erview at the time of record			all regulatory requirements.		
	review, the Mainten	ance Director confirmed the			Our date of compliance is		
	lack of sprinkler sys	stem inspections on the control			8/16/2024.		
	valves during the pa	ast 12 months.					
	This finding was rev	viewed with the Director of					
	Nursing and Mainte	enance Director during the exit					
	conference on 07/11	1/24.					
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include t	he transmission of a fire					
	alarm signal and s	simulation of emergency fire					
	conditions. Fire dri	ills are held at expected					
	and unexpected til	mes under varying					
	conditions, at leas	t quarterly on each shift.					
	The staff is familia	r with procedures and is					
	aware that drills ar	re part of established					
	routine. Where dr	ills are conducted between					
	9:00 PM and 6:00	AM, a coded					
	announcement ma	ay be used instead of					
	audible alarms.						

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 10 of 135

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155770	B. W	NG		07/11/	/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY			
WATERS	S OF GEORGETOV	NN THE			GETOWN, IN 47122			
WAILING	. GEORGETON	VIN, 111L		OLOIK	3L10WN, IN 47122			
(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	ιΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	19.7.1.4 through							
		I review and interview, the	K 0	712	K712 – Building 08 - It is the		08/16/2024	
		ovide quarterly fire drill			intent of the facility to ensure	:О		
		3 of 3 shifts during 3 of 4			provide quarterly fire drill			
	_	cient practice could affect all			documentation for 3 shifts dur	-		
		s staff and visitors in the			all 4 quarters and to ensure fi			
	facility.				drill reports included complete			
					documentation of the transmis	ssion		
	Findings include:				of a fire alarm signal to the			
	l				monitoring company/fire			
		f the facility's fire drill reports			department during the past tw			
		en 10:15 a.m. and 4:30 p.m. with			months to meet set standards			
		irector present, the facility was			1 CORRECTIVE ACTIONS	3		
		e eight documented fire drill			TAKEN:			
		12 month period. The			a On 8/6/2024 the			
	_	d quarters were missing fire drill			Administrator in-serviced the			
	reports:				Maintenance Supervisor/desig			
	·	lay) of the third quarter (July,			on the requirement that fire dr			
	August, and Septer				must be conducted at unexpe			
		t (evening) of the third quarter			times under varying conditions			
		September), and fourth quarter			least quarterly on each shift a	nd		
		er, and December) of 2023, and			documented to meet set			
	• `	ry, February, and March) of			standards.			
	2024.	. 10 64 4. 1			b On 8/6/2024 the			
		night) of the third quarter (July,			Administrator in-serviced the			
	August, and Septer	nber) of 2023. The time of record review,			Maintenance Supervisor/desig	jnee		
		*			on the requirement to include			
		irector confirmed the lack of			documentation for the			
	_	the previously mentioned			transmission of the alarm to the			
	shifts and quarters				monitoring company to meet standards.	, C l		
	This finding was re	eviewed with the Director of						
	_	enance Director during the exit			c On 8/6/2024 the Administrator in-serviced the			
	conference on 07/1	2			Maintenance Supervisor/design	nnee		
		1/27.			on the requirement to ensure	-		
	2 1 10(b)				drills are held on varied dates			
	3.1-19(b) 3.1-51(c)				all shifts and quarters to meet			
	3.1-51(c)				standards.	361		
	2 Rased on record	I review and interview, the			2 ALL OTHERS WITH			
		sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECTI	ED:		
	I racinty ranted to en	sare 5 or 6 mic arm reports	1		I FOIENTIAL TO DE AFFECTI	_U.	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLET	ED
		155770	B. W	ING		07/11/20	024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ISTER BARBARA WAY		
WATERS	OF GEORGETON	VN. THE			GETOWN, IN 47122		
	1		1		1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	_	documentation of the			a All residents and all staf		
		re alarm signal to the			and visitors have the potential	to	
	monitoring company/fire department during the				be affected but none were.		
	1 ~	LSC 19.7.1.4 requires fire			3 MEASURES TO PREVE	INT	
		occupancies shall include the			REOCCURRENCE:		
		fire alarm signal and			a Maintenance		
		gency conditions. This			Supervisor/designee will ensu	re	
	deficient practice co	ould affect all residents.			fire drills are conducted at		
	E' 1' ' 1 1				unexpected times under varyi	-	
	Findings include:				conditions at least quarterly of		
	D 1	24 C 72 L C 1711			each shift and that documenta		
		the facility's fire drill reports			be retained in the facility's Life		
		en 10:15 a.m. and 4:30 p.m. with			Safety Binder and all reports v	VIII	
		rector present, 3 of 8 fire drill			have documentation for the		
		luring the past 12 month period			transmission of the alarm to th	ne	
	_	with documentation for the			monitoring company and will		
		alarm to the monitoring			ensure fire drills are held on v		
		rill dates and times include:			dates for all shifts and quarter		
	_	m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Preventi	ve	
	_	d on interview at the time of			Maintenance Program and		
		Maintenance Director			document those inspection re		
	_	e was no information on 3 of 8			as appropriate. If any issues		
	_	verify that transmission of the			discovered, they will be addre		
	alarm was received	by the monitoring company.			and resolved immediately. Th		
	Tl.:- C J.	-idid-dDi (C			Maintenance Supervisor/designation		
	_	viewed with the Director of			will review with the Administra	itor	
	_	enance Director during the exit			the inspection results.		
	conference on 07/1	1/24.			b The Administrator will		
	3-1.19(b)				monitor adherence to the		
	` ′				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
	2 Događ an maa 1	raviary and interview the			Preventative Maintenance		
		review and interview, the sure fire drills were held on			documentation is in place.		
	1	shifts and quarters. This			4 MONITORING CORRECTIVE ACTION:		
		ould affect all residents in the					
		oute affect an residents in the			a The inspection results w		
	facility.				be presented by the Maintena	nce	
	Findings :11				Supervisor/designee to the		
	Findings include:				Administrator monthly and the	;	
	I		1		Administrator will present the	1	

08/02/2024 PRINTED: 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. BUILDING COMPLETED 01 155770 B. WING 07/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (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 Based on review of the facility's fire drill reports inspection results at the monthly on 07/10/24 between 10:15 a.m. and 4:30 p.m. with Quality Assurance/Performance the Maintenance Director present, there were Improvement (QA/PI) meeting. eight documented fire drills performed during the Inspection results and system past 12 month period and on three occasions components will be reviewed by there were two fire drills performed on the same the QA/PI Committee with day (10/26/23, 02/27/24, and 05/28/24). Based on subsequent plans of correction interview at the time of record review, the developed and implemented as Maintenance Director acknowledged there were deemed necessary to ensure only eight fire drills documented during the past compliance is maintained. 12 month period and there were three occasions This plan of correction where two fire drills were performed during the constitutes our credible same day. allegation of compliance with all regulatory requirements. This finding was reviewed with the Director of Our date of compliance is Nursing and Maintenance Director during the exit 8/16/2024. conference on 07/11/24. K914 - Building 01 - It is the 3.1-19(b) intent of the facility to ensure 3.1-51(c)complete documentation is available for all non hospital grade electrical receptacles in all resident room locations are tested at least annually to meet set standards. **CORRECTIVE ACTIONS** TAKEN: On 8/7/2024 the Maintenance Supervisor/designee conducted the annual electrical receptacle inspection and documented the results in the facilities Life safety binder to meet set standards. The Administrator verified repairs on 8/7/2024. **ALL OTHERS WITH** POTENTAL TO BE AFFECTED: All residents and all staff and visitors have the potential to be affected but none were.

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 13 of 135

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/11/2024
	ROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				REOCCURRENCE: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/desi on the requirement the annual electrical receptacle inspection and testing must be completed annually and documented in the standards. b Maintenance Supervisor/designee will ensu the annual electrical receptact inspection and testing is completed and documented at part of the facility's Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/desi will review with the Administrate 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 was the monte of the presented by the Maintenance Supervisor/designee to the Administrator and the Administrator will present the inspection results at the monte of the presented of the presented by the Maintenance supervisor/designee to the presented by the Maint	gnee al an ad dhe as a e asults are assed ae gnee ator vill ance

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155770	ILDING	01	COMPL 07/11/	ETED
	PROVIDER OR SUPPLIER		1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, recommendational testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch activates both visual LIM circuits with an manual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the	- Maintenance and - Maintenance and - Maintenance and - Maintenance and - Peptacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing Seperformed at intervals rented performance data Sted as hospital-grade at received at intervals not - Sted at intervals of - The tested at intervals less - The test		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 8/16/2024.	py n s	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 15 of 135

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 CON			
		155770	B. W	ING		07/11/20)24
	PROVIDER OR SUPPLIER		•	1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
	1				T	<u> </u>	(37.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE
TAG	associated repairs			IAG			DATE
	containing date, room or area tested, and results.						
	6.3.4 (NFPA 99)						
	·	on, record review and	K 0	914	K914 – Building 08 - It is the		08/16/2024
		ty failed to ensure complete	110	,	intent of the facility to ensure		,0,10,202.
	documentation was	-			complete documentation is		
	nonhospital-grade e	electrical receptacles in all			available for all non hospital of	grade	
	resident room locati	ions tested at least annually.			electrical receptacles in all		
	NFPA 99, Health C	are Facilities Code 2012 Edition,			resident room locations are te	sted	
	Section 6.3.4.1.3 sta	ates receptacles not listed as			at least annually to meet set		
	hospital-grade, at pa	atient bed locations and in			standards.		
		p sedation or general			1 CORRECTIVE ACTIONS	S	
		istered, shall be tested at			TAKEN:		
		ling 12 months. Additionally,			a On 8/7/2024 the		
		ceptacle Testing in Patient Care			Maintenance Supervisor/desig		
	_	physical integrity of each			conducted the annual electric	al	
	_	confirmed by visual inspection.			receptacle inspection and		
	I	ne grounding circuit in each			documented the results in the		
	_	shall be verified. Correct			facilities Life safety binder to r		
	1 * *	nd neutral connections in			set standards. The Administra	ator	
		ptacle shall be confirmed; and			verified repairs on 8/7/2024.		
		ne grounding blade of each			2 ALL OTHERS WITH		
	_	e (except locking-type e not less than 115 grams (4			POTENTAL TO BE AFFECTE a All residents and all staf	l l	
		e not less than 113 grams (4			a All residents and all state and visitors have the potential		
	residents.	em praemee could affect all			be affected but none were.	io	
	Testucines.				3 MEASURES TO PREVE	NT	
	Findings include:				REOCCURRENCE:		
					a On 8/6/2024 the		
	Based on record rev	view on 07/10/24 between 10:15			Administrator in-serviced the		
		with the Maintenance Director			Maintenance Supervisor/design	nee	
	_	o documentation available of			on the requirement the annua		
	1 -	oom receptacle test for non			electrical receptacle inspectio		
		otacles. Based on interview at			and testing must be complete		
		eview, the Maintenance			annually and documented in t		
	Director said all of	the electrical receptacles in			life safety binder to meet set		
	resident rooms were				standards.		
		s he knew. He further said he			b Maintenance		
	_	mentation to show that annual			Supervisor/designee will ensu	re	

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BUILDING B. WING	01	COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	testing per NFPA 99 requirements was minformation within prior. Based on obstetween 9:45 a.m. athe facility with the were at least four elresident room.	P, Receptacle Testing thet with all pertinent the past 12 month period or servations on 07/11/24 and 12:15 p.m. during a tour of Maintenance Director, there the ectrical receptacles in each wiewed with the Director of the servations of the servat		the annual electrical receptace inspection and testing is completed and documented a part of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/desi will review with 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 where the presented by the Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results where the inspection results at the monity of the monity of the presented by the Maintenance supervisor/designee to the Administrator and the Administrator will present the inspection results at the monity of the present (QA/PI) meeting inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our data of compliance with all regulatory requirements.	cile as a e esults s are essed he ignee ator thly nce g h by on as

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 17 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING <u>01</u> COMP			(X3) DATE COMPL 07/11 /	ETED	
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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)	TE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availal and circuits are m and separate from Minimizing the pos- emergency power consideration for re-	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised intervals, and exercised intervals and conditions include and transfer of all EES inducted by competent in ance and testing of stored in the formation of the inspected annually, and a dically exercising the inspected annually, and a dically exercising the inspected annually and a dically exercising the inspected annually, and a dically exercising the inspected annually and a dically exercising the inspected annually, and a dically exercising the inspected annually.			8/16/2024.		

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 18 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024		
NAME OF F	PROVIDER OR SUPPLIER	•			DDRESS, CITY, STATE, ZIP COD		
WATERS	OF GEORGETOV	VN, THE			STER BARBARA WAY SETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA		DEFICIENCY)		DATE
		view and interview, the facility	K 0918		K918 – Building 08 - It is the		08/16/2024
		complete written record of			intent of the facility to ensure		
		oad testing for 1 of 1 generator			maintain a complete written re		
		12 months. Chapter			of monthly generator load test	ing	
		12 NFPA 99 requires monthly			for generator during the past		
		ator serving the emergency			twelve months to meet set		
	1	be in accordance with NFPA			standards.	•	
		or Emergency and Standby hapter 8. Chapter 6.4.4.2 of			1 CORRECTIVE ACTIONS TAKEN:	5	
		written record of inspection,					
		ising period, and repairs for the					
	_	ularly maintained and available			Maintenance Supervisor		
	for inspection by th	-			conducted the monthly load		
		er 6-4.4.1.3 of 2012 NFPA 99			testing for the emergency	_	
		or on-site generators shall be			generator and documented th		
		dance with NFPA 110, 2010			results in the facilities Life Saf	еіу	
		or Emergency and Standby			Binder to meet set standards.		
		3.7 requires storage batteries,			The Administrator verified the	work	
	1	e levels or battery voltage,			on 7/15/2024. 2 ALL OTHERS WITH		
		with systems shall be				ED:	
		nd maintained in full		POTENTIAL TO BE AFFECTED: a All residents and all staff			
		anufacturer's specifications.			 All residents and all staff and visitors have the potential 		
		tive batteries shall be repaired			be affected but none were.	10	
		ately upon discovery of			3 MEASURES TO PREVE	NT	
	*	5.4.2 of NFPA 99 requires a			REOCCURRENCE:		
	•	spection, performance,			a On 8/6/2024 the		
		nd repairs shall be regularly			Administrator in-serviced the		
		ilable for inspection by the			Maintenance Supervisor/design	nee	
		risdiction. This deficient			on the requirement to conduct	-	
	, ,	et all residents, staff and			testing on the emergency	· uii	
	visitors.	,			generator including the month	lv	
					testing to meet set standards.	-	
	Findings include:				b The Maintenance		
					Supervisor/designee will ensu	re to	
	Based on review of	the generator inspection and			conduct all testing on the		
		7/10/24 between 10:15 a.m. and			emergency generator includin	g the	
		Maintenance Director present,			monthly load testing as a part	_	
	_	ly generator load test			the facility's Preventive		
		lable for June of 2024 for the			Maintenance Program and		
		or. Based on interview at the			document those inspection re	sults	

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155770	B. WI	ing		07/11/2024	
	PROVIDER OR SUPPLIE			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(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	TE COM	PLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ew, the Maintenance Director			as appropriate. If any issues		
		s been in a transition period			discovered, they will be addre		
		p and the monthly load test of			and resolved immediately. Th		
	the emergency gen	erator was not completed.			Maintenance Supervisor/desig		
					will review with the Administra	tor	
		eviewed with the Director of			the inspection results.		
	_	enance Director during the exit			c The Administrator will		
	conference on 07/1	1/24.			monitor adherence to the		
	2.1.10(%)				Preventative Maintenance		
	3.1-19(b)				schedule and validate the Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w	iii l	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performand	•	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	ру	
					the QA/PI Committee with		
					subsequent plans of correction	n	
					developed and implemented a	s	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements. Our date of compliance is		
					8/16/2024.		
					0/10/2024.		
K 0000							
Bldg. 03							

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 20 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		r í	UILDING	instruction 03	(X3) DATE S COMPL: 07/11/	ETED	
	ROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 07/1 Facility Number: 0 Provider Number: 4 AIM Number: 2009 At this Life Safety Office Georgetown, was for Requirements for Provider Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L 1004 was surveyed Health Care Occupation of the Company	11509 155770 209280 Code survey, The Waters of bund not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), and 410 IAC 16.2. Villa with Chapter 19, Existing ancies. Ity was determined to be of ruction and fully sprinkled, re alarm system with smoke ridors, spaces open to the sident sleeping rooms. The try of 10 and had a census of 8 sit. In the structure of the sident sleeping rooms and fully sprinkled. The sident sleeping rooms are sident sleeping rooms. The try of 10 and had a census of 8 sit.	K 0	0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepa and/or executed in complian with state and federal laws. This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is August 16, 2024. This provice respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.	the s red ice	
K 0291 SS=F Bldg. 03	NFPA 101 Emergency Lightir Emergency Lightin Emergency lightin duration is provide	ng g of at least 1-1/2-hour					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 21 of 135

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE	I	ID	I		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
TAG	accordance with 7 18.2.9.1, 19.2.9.1 Based on record review; the facility documentation was of 10 battery power were tested monthly the past 12 months, during the past 12 r would provide light outages, furthermore emergency light untested. LSC 19.2.9 shall be provided in Section 7.9.3.1.1 (1 shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a testing shall be conducted weeks and a testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less than 30 testing shall be conducted weeks and a maximfor not less t	A LSC IDENTIFYING INFORMATION 7.9. View, observation, and ty failed to ensure provided for the testing of 10 red emergency light units that y for 30 seconds during 12 of and annually for 90 minutes months to ensure the light ting during periods of power re, 9 of 10 battery powered its failed to operate when 1 requires emergency lighting a accordance with Section 7.9.) requires functional testing monthly, with a minimum of 3 mum of 5 weeks between tests, seconds, (3) Functional ducted annually for a minimum emergency lighting system is d (5) Written records of visual s shall be kept by the owner	K 0	TAG	Building 04 - K291 – It is the intent of the facility to ensure documentation is provided for testing of battery powered emergency light units that are tested monthly for 30 second during 12 of the past 12 month and annually for 90 minutes of the past 12 months to ensure light would provide lighting duperiods of power outages and ensure battery powered emergency light units operate meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 8/7/2024 the Maintenance Supervisor/desi performed the monthly testing the 10 battery powered emerging the investigation of the annual testing of the battery powered emergency light units located in each bathroom in Villa 4 and perform the annual testing of the battery powered emergency light units and documented the results if facilities life safety binder to meet standards. The Administr verified the work on 8/7/2024 2.ALL OTHERS WITH POTENTIAL TO BE AFFECT 1.All residents and all stand visitors have the potential be affected but none were. 3.MEASURES TO PREVEN REOCCURRENCE: 1.On 8/6/2027 the Administrator in-serviced the Maintenance Supervisor/desi	r the es sths during the uring d eto gnee g of gency rmed ery ts n the neet rator . ED: aff all to	DATE 08/16/2024

If continuation sheet

PRINTED: 08/02/2024 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. BUILDING COMPLETED 03 155770 B. WING 07/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE between 9:45 a.m. and 12:15 p.m. during a tour of on the requirement to ensure the facility with the Maintenance Director, 9 of 10 documentation is provided for the battery powered emergency light units did not testing of battery powered illuminate when tested. Based on an interview at emergency light units including the time of record review, the Maintenance monthly and annual testing and Director said he was not aware of any battery documented in the facilities life powered emergency light units in any of the safety binder to meet set Villas, furthermore, based on interview at the time standards. of observations of the battery powered 2.Maintenance emergency light units, the Maintenance Director Supervisor/designee will ensure said he has not tested the light units because he documentation is provided for the did not know they were there. A short time later, testing of battery powered the Maintenance Director said he realized the emergency light units including battery powered emergency light units were in monthly and annual testing and each bathrooms because this Villa does not have documented in the facilities life an emergency generator. safety binder as a part of the facility's Preventive Maintenance This finding was reviewed with the Director of Program and document those Nursing and Maintenance Director during the exit tests on the Battery-Operated conference on 07/11/24. Emergency Lights and signs Test Log and will maintain emergency 3.1-19(b) lighting to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVE ACTION: 1.The inspection results will

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

be presented by the Maintenance Supervisor/designee to the Administrator monthly and the

Page 23 of 135

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED
		155770	B. WING		07/11/2024
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0345	NFPA 101			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 8/16/2024.	oe
SS=F Bldg. 03	Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are readed. 1. Based on record facility failed to ensign the system.	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K345 – Building 8 - It is the intent of the facility to ensure t annual testing of all devices	08/16/2024 he
	performed. NFPA the 2010 Edition, at inspections, testing, provided that include	72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be les the following information all the applicable information		connected to fire alarm system are performed and to maintain alarm system in accordance w NFPA 72, as required by LSC Sections 19.3.4.5.1 and 9.6 ar	fire vith 101

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

requested in Figure 14.6.2.4:

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

ensure complete documentation is

Page 24 of 135

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIEI		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
	(1) Date (2) Test frequency (3) Name of proper (4) Address (5) Name of person maintenance, tests, affiliation, business number (6) Name, address, approving agency ((7) Designation of (8) Functional test operations (10) Check of all sr (11) Loop resistance line-type heat detect (12) Functional test control units (13) Functional test system to silence fr (14) Functional test system to silence fr (15) Tests of intellicular system (16) Other tests as a manufacturer's pub (17) Other tests as a having jurisdiction (18) Signatures of t representative (19) Disposition of (e.g., system owner corrected/successfu abandoned in place This deficient pract in the facility.	performing inspection, or combination thereof, and address, and telephone and representative of ies) the detector(s) tested of detectors of required sequence of moke detectors e for all fixed-temperature, stors of mass notification system to fability of mass notification re alarm notification appliances gibility of mass notification required by the equipment lished instructions required by the authority ester and approved authority problems identified during test rootified, problem illy retested, device		available for the sensitivity test of all hard wired smoke detected and to show what testing instrument is used to test all smoke detectors for sensitivity meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 8/9/2024 the facilities licensed contractor performed annual fire alarm system inspection / test report and documented in the facilities Lift Safety Binder to meet set standards. The Administrator verified the work on 8/9/2024. b On 8/9/2024 the facilities licensed contractor performed semi-annual visual fire alarm system inspection and documented in the facilities Lift Safety Binder to meet set standards. The Administrator verified the work on 8/9/2024. c On 8/9/2024 the facilities license contractor performed the biannual sensitivity testing on the fire alarm system smoke detectors and documented the results in the Life Safety Binder and also documented the manufacturer's calibrated sensitivity test instrument from fire alarm system inspection contractor to meet set standard the results in the Life Safety Binder and also documented the manufacturer's calibrated sensitivity test instrument from fire alarm system inspection contractor to meet set standard the Administrator verified the son 8/9/2024. 2 ALL OTHERS WITH	ting ors to to the the the the the the	
	Findings include:		1	POTENTIAL TO BE AFFECTE	:D:	

All residents and all staff

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	03	COMPLETED
		155770	B. W	ING		07/11/2024
NAME OF F			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER			1002 S	ISTER BARBARA WAY	
WATERS	OF GEORGETOW	/N, THE		GEOR	GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(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		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE
		view on 07/10/24 between 10:15			and visitors have the potential	to
		with the Maintenance Director			be affected but none were.	
	1 -	was unable to provide an			3 MEASURES TO PREVE	:NI
		rstem inspection/test report ne past 12 month period. The			REOCCURRENCE:	
	most recent annual				a On 8/6/2024 the Administrator in serviced the	
		rt was dated 06/14/23				nnoo
		cility's fire alarm system			Maintenance Supervisor/design on the requirement to ensure	
		nterview at the time of record			alarm systems are maintained	
		nfirmed by the Maintenance			properly including the semi-ar	
	Director.	infined by the Maintenance			and annual fire alarm system	illuai
	Director.				inspections and testing	
	This finding was re	viewed with the Director of			documents to be retained in the	ne l
		enance Director during the exit			facilities Life Safety Binder an	
	conference on 07/1				ensure the smoke detector	a to
					sensitivity test of all hard wire	d
	3.1-19(b)				smoke detectors contains the	
					name of the manufacturer's	
	2. Based on record	review and interview, the			calibrated sensitivity test	
		intain 1 of 1 fire alarm system in			instrument to meet set standa	rds.
	1	FPA 72, as required by LSC 101			b Maintenance	
		and 9.6. NFPA 72, Section			Supervisor/designee will ensu	re
		lless otherwise permitted by			fire alarm systems are mainta	
	14.3.2, visual inspec	ctions shall be performed in			properly including the semi-ar	
	_	e schedules in Table 14.3.1, or			and annual fire alarm system	
	more often if requir	ed by the authority having			inspections and testing	
	jurisdiction. Table	14.3.1 states that the following			documents to be retained in the	ne
	must be visually ins	spected semi-annually:			facilities Life Safety Binder an	d to
	a. Control unit troul	ole signals			ensure the smoke detector	
	b. Remote annuncia	itors			sensitivity test of all hard wire	d
	c. Initiating devices	(e.g. duct detectors, manual			smoke detectors contains the	
	fire alarm boxes, he	at detectors, smoke detectors,			name of the manufacturer's	
	etc.)				calibrated sensitivity test	
	d. Notification appl				instrument as a part of the	
	e. Magnetic hold-op				facility's Preventive Maintenar	nce
	_	ice could affect all residents,			Program and document those	
	staff, and visitors in	the facility.			inspection results as appropri	ate.
					If any issues are discovered, t	they
	Findings include:				will be addressed and resolve	d
					immediately The Maintenand	re l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 03		03	COMPL	ETED
		155770	B. W	ING		07/11/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record rev	view on 07/10/24 between 10:15			Supervisor/designee will revie	W	
	a.m. and 4:30 p.m.	with the Maintenance Director			with the Administrator the		
	present, there was r	no documentation provided			inspection results.		
	regarding a semi-ar	nnual visual fire alarm system			c The Administrator will		
	inspection during th	ne past 12 month period. The			monitor adherence to the		
	only fire alarm syst	em inspection/test provided			Preventative Maintenance		
	was dated 06/14/23	for an annual fire alarm			schedule and validate the		
	inspection/test by th	ne facility's vendor. Based on			Preventative Maintenance		
		e of record review, the			documentation is in place.		
	Maintenance Direct	tor confirmed there was no			4 MONITORING		
	semi-annual visual	inspection of the facility's fire			CORRECTIVE ACTION:		
		es performed during the past			a The inspection results w	ill	
	12 month period.			be presented by the Maintenance			
	·			Supervisor/designee to the			
	This finding was re	viewed with the Director of			Administrator and the		
		enance Director during the exit		Administrator will present the			
	conference on 07/1	_			inspection results at the month	nlv	
					Quality Assurance/Performan	-	
	3.1-19(b)				Improvement (QA/PI) meeting		
					Inspection results and system		
	3 Based on record	review and interview, the			components will be reviewed		
		sure complete documentation			the QA/PI Committee with	o y	
		e sensitivity testing of all hard			subsequent plans of correction	n	
		ors, and to show what testing			developed and implemented a		
		d to test all smoke detectors			deemed necessary to ensure	13	
		PA 72, National Fire Alarm			compliance is maintained.		
		, Section 14.4.5.3.1 states			This plan of correction		
		shall be checked within 1 year			constitutes our credible		
	1	every alternate year thereafter.			allegation of compliance with	h	
		quired calibration test, if					
		icate that the detector has			all regulatory requirements.		
	· ·	listed and marked sensitivity			Our date of compliance is 8/16/2024.		
		time between calibration tests			0/10/2024.		
		o be extended to a maximum of					
	•						
		uency is extended, records of					
		sance alarms and subsequent					
		ms shall be maintained. In					
		re nuisance alarms show an					
		revious year, calibration tests					
	shall be performed.	To ensure that each smoke					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		î ´	JILDING	nstruction <u>03</u>	(X3) DATE COMPL 07/11/	ETED	
	ROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	detector is within it range, it shall be tes (1) Calibrated test r (2) Manufacturer's instrument. (3) Listed control e purpose. (4) Smoke detector arrangement where at the control unit wits listed sensitivity (5) Other calibrated to the authority hav Detectors found to listed and marked s cleaned and recalib The detector sensiti measured using any an unmeasured con detector. This deficient residents, staff, and Findings include: Based on record revalum. and 4:30 p.m. present, there was reshow a smoke detect wired smoke detect the past 24 month p	s listed and marked sensitivity sted using any of the methods: method. calibrated sensitivity test quipment arranged for the /fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be		TAG	DEFICIENCY)		DATE
	_	viewed with the Director of enance Director during the exit 1/24.					
	3.1-19(b)						

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 28 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIER		1002	ET ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY RGETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
K 0353 SS=F Bldg. 03	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and test secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkler system automatic sprinkler 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to provide the evidence the shad been inspected for 1 of 1 sprinkler any device, equipm compliance with the accordance with approximate Sprinkler systems is accordance with NF Inspection, Testing, Water-Based Fire Parameters of the systems of the	supply source RKS information on non-required or partial or system.	K 0353	K353 – Building 08 It is the information of the facility to ensure to prowritten documentation or oth evidence the sprinkler system components have been insperant tested for 1 of 4 quarters the sprinkler system and to ensure to document sprinkler system inspections in accord with NFPA 25 the dry sprinkler system's pressure gauges and during 10 of the past 12 mon for the sprinkler system's convalves to meet set standards 1.CORRECTIVE ACTIONS TAKEN: 1.On 8/9/2024 the facility licensed sprinkler contractor performed the quarterly sprinkler contractor perfor	ovide er m ected s for r dance er nd diths ntrol s.

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

Event ID:

OZM221 Facility ID: 011509 If continuation sheet Page 29 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>03</u>		COMPLETED	
		155770	B. W	ING		07/11/2	2024
		<u> </u>	-	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN. THE			GETOWN, IN 47122		
	1		1		1	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		e. NFPA 25, 5.2.5 requires that			inspection and documented th		
		vices shall be inspected			results in the facilities Life Saf	, I	
		they are free of physical			Binder to meet set standards.		
	_	, 5.3.3.1 requires the mechanical evices including, but not limited			The Administrator verified the	work	
		ngs, shall be tested quarterly.			on 8/9/2024.		
	_	ne-type and pressure			2.On 7/31/2024 the	rmad	
	^	ow alarm devices shall be			Maintenance Supervisor perfo	rmea	
		7. This deficient practice could			the weekly inspection of the		
		staff, and visitors in the			facilities dry sprinkler system		
	facility.	starr, and visitors in the			gauges and documented the		
	lacility.				results in the facility life safety binder to meet set standards.	1	
	Findings include:				Administrator verified the worl		
	rindings include.				7/31/2024.	COII	
	Rosed on review of	the quarterly sprinkler system			3.On 7/31/2024 the		
		on 07/10/24 between 10:15 a.m.			Maintenance Supervisor perfo	rmod	
	_	the Maintenance Director			the monthly inspection of the	Jilleu	
	_	no quarterly sprinkler system			facilities sprinkler system conf	rol	
	_	vailable for the second quarter			valves and documented the re		
		nne) of 2024. Based on			in the facility life safety binder		
		ne of record review, the			meet set standards. The	10	
		tor confirmed there was no			Administrator verified the worl	(on	
		ion available to show the			7/31/2024 .	COII	
		d been inspected during the			2.ALL OTHERS WITH		
	second quarter of 2	-			POTENTIAL TO BE AFFECTI	FD·	
		~ - ·-			1.All residents and all sta		
	This finding was re	viewed with the Director of			and visitors have the potential		
	_	enance Director during the exit			be affected but none were.	-	
	conference on 07/1	_			3.MEASURES TO PREVEN	т	
					REOCCURRENCE:		
	3.1-19(b)				1.On 8/6/2024 the		
					Administrator in serviced the		
	2. Based on record	review, observation, and			Maintenance Supervisor/desig	gnee	
		ity failed to document sprinkler			on the requirement to ensure		
		in accordance with NFPA 25			sprinkler inspections are		
		kler system during 47 of the			conducted and documented		
		he sprinkler system's pressure			including the quarterly sprinkle	er	
	_	10 of the past 12 months for			inspection, weekly inspection		
		n's control valves. NFPA 25,			the gauges and the monthly		
	1 -	Standard for the Inspection, Testing, and			inspection of the control valve	s to	

PRINTED: 08/02/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED	
155770		B. WING		07/11	/2024	
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	S.		SISTER BARBARA WAY		
WATERS	OF GEORGETOW	/N, THE		RGETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	RIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE
	Maintenance of Wa	ter-Based Fire Protection		meet set standards.		
	Systems, 2011 Edit	ion, Section 5.2.4.2 states		2.Maintenance		
	gauges on dry pipe	sprinkler systems shall be		Supervisor/designee will ens	sure	
	inspected weekly to	ensure that normal air and		sprinkler inspections are		
	water pressures are	being maintained. Section		conducted and documented		
	5.1.2 states valves a	and fire department		including the quarterly sprink	der	
	connections shall be	e inspected, tested, and		inspection, weekly inspection	า of	
	maintained in accor	dance with Chapter 13.		the gauges and the monthly		
	Section 13.1.1.2 sta	tes Table 13.1.1.2 shall be		inspection of the control valv	es as	
	utilized for inspecti	on, testing and maintenance of		a part of the facility's Preven	tive	
	valves, valve compo	onents and trim. Section 4.3.1		Maintenance Program and		
	states records shall	be made for all inspections,		document those inspection r	esults	
	tests, and maintenar	nce of the system and its	as appropriate. If any issues are			
	components and sha	all be made available to the	discovered, they will be addressed			
	authority having jur	risdiction upon request. This		and resolved immediately.	īhe .	
	deficient practice co	ould affect all residents, staff,		Maintenance Supervisor/des	signee	
	and visitors in the fa	acility.		will review with the Administ	rator	
				the inspection results.		
	Findings include:			3.The Administrator will	İ	
				monitor adherence to the		
	a. Based on record	review on 07/10/24 between		Preventative Maintenance		
	10:15 a.m. and 4:30	p.m. with the Maintenance		schedule and validate the		
	Director present, the	ere was no documentation		Preventative Maintenance		
	available to show th	ne facility's dry sprinkler		documentation is in place.		
	system gauges were	e inspected weekly during 47		4.MONITORING CORREC	TIVE	
		period. The only weekly		ACTION:		
	_	pections were for the weeks in		1.The inspection results	s will	
	June and July of 20	24. Based on interview at the		be presented by the Mainter		
	_	w, the Maintenance Director		Supervisor/designee to the		
		s no documentation available		Administrator monthly and th	ne	
		ility's sprinkler gauges have		Administrator will present the		
		ast weekly during 47 of the		inspection results at the mor		
	_	ed on observations on		Quality Assurance/Performa	-	
	_	:45 a.m. and 12:15 p.m. during a		Improvement (QA/PI) meetir		
		vith the Maintenance Director		Inspection results and system	_	
				components will be reviewed		
the facility had two pressure gauges at the sprinkler riser.			the QA/PI Committee with	,		

b. Based on record review on 07/10/24 between

10:15 a.m. and 4:30 p.m. with the Maintenance

subsequent plans of correction

developed and implemented as

deemed necessary to ensure

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024		
	PROVIDER OR SUPPLIER			1002 SI	NDDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	system control valv for 10 of the past 12 inspections availabl 2024. Based on into review, the Mainten	ere was no monthly sprinkler es inspection documentation 2 months. The only monthly le were for June and July of erview at the time of record hance Director confirmed the stem inspections on the control last 12 months.		compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/16/2024.			
	-	viewed with the Director of enance Director during the exit 1/24.					
K 0712 SS=F Bldg. 03	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills al routine. Where dr 9:00 PM and 6:00	ay be used instead of					
	Based on record facility failed to produce documentation for a quarters. This deficition	review and interview, the swide quarterly fire drill 3 of 3 shifts during 3 of 4 cient practice could affect all s staff and visitors in the	K 0	712	K712 – Building 08 - It is the intent of the facility to ensure to provide quarterly fire drill documentation for 3 shifts duri all 4 quarters and to ensure fir drill reports included complete documentation of the transmis of a fire alarm signal to the	ng e	08/16/2024
	Based on review of	the facility's fire drill reports			monitoring company/fire department during the past two	elve	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 32 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>03</u> COMP			ETED
		155770	B. W	ING		07/11/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
\\/\TED	S OF GEORGETON	NN THE			GETOWN, IN 47122		
WATERS	OF GEORGETON	VIN, THE		GEORG	3E 1 O WIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
	on 07/10/24 between	en 10:15 a.m. and 4:30 p.m. with			months to meet set standards		
	the Maintenance D	irector present, the facility was			1 CORRECTIVE ACTIONS	S	
	only able to provid	e eight documented fire drill			TAKEN:		
	reports for the past	12 month period. The			a On 8/6/2024 the		
	following shifts and	d quarters were missing fire drill			Administrator in-serviced the		
	reports:				Maintenance Supervisor/design	gnee	
	a. The first shift (d	lay) of the third quarter (July,			on the requirement that fire dr	ills	
	August, and Septer	mber) of 2023.			must be conducted at unexpe	cted	
	b. The second shif	t (evening) of the third quarter			times under varying conditions	s at	
	(July, August, and	September), and fourth quarter			least quarterly on each shift a	nd	
	(October, November	er, and December) of 2023, and			documented to meet set		
	first quarter (Janua	ry, February, and March) of			standards.		
	2024.				b On 8/6/2024 the		
	c. The third shift (1	night) of the third quarter (July,			Administrator in-serviced the		
	August, and Septer	mber) of 2023.			Maintenance Supervisor/design	gnee	
	Based on interview	at the time of record review,			on the requirement to include		
	the Maintenance D	irector confirmed the lack of			documentation for the		
	fire drill reports for	the previously mentioned			transmission of the alarm to the	ne	
	shifts and quarters				monitoring company to meet s	set	
					standards.		
	This finding was re	eviewed with the Director of			c On 8/6/2024 the		
	Nursing and Maint	enance Director during the exit			Administrator in-serviced the		
	conference on 07/1	1/24.			Maintenance Supervisor/design	gnee	
					on the requirement to ensure	fire	
	3.1-19(b)				drills are held on varied dates	for	
	3.1-51(c)				all shifts and quarters to meet	set	
					standards.		
	2. Based on record	I review and interview, the			2 ALL OTHERS WITH		
	facility failed to en	sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECTI	ED:	
	included complete	documentation of the			a All residents and all staf	f	
	transmission of a fi	re alarm signal to the			and visitors have the potential	to	
	monitoring compar	ny/fire department during the			be affected but none were.		
	past twelve months	s. LSC 19.7.1.4 requires fire			3 MEASURES TO PREVE	:NT	
	drills in health care	occupancies shall include the			REOCCURRENCE:		
	transmission of the	fire alarm signal and			a Maintenance		
	simulation of emer	gency conditions. This			Supervisor/designee will ensu	re	
	deficient practice c	ould affect all residents.			fire drills are conducted at		
					unexpected times under varyi	ng	
	Findings include:				conditions at least quarterly of	-	
1 mangs metaus.		1		each shift and that documents			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLE	ΓED
		155770	B. WING 07/11/2024				024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			ISTER BARBARA WAY		
WATERS	OF GEORGETON	VN, THE			GETOWN, IN 47122		
			ı		<i>,</i> I	<u> </u>	OLE:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		the facility's fire drill reports			be retained in the facility's Life		
		n 10:15 a.m. and 4:30 p.m. with			Safety Binder and all reports v	VIII	
		rector present, 3 of 8 fire drill			have documentation for the		
		luring the past 12 month period			transmission of the alarm to th	ne	
	-	with documentation for the			monitoring company and will		
		alarm to the monitoring			ensure fire drills are held on v		
		rill dates and times include:			dates for all shifts and quarter		
	-	m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Preventi	ve	
	-	d on interview at the time of			Maintenance Program and		
		Maintenance Director			document those inspection res		
		e was no information on 3 of 8			as appropriate. If any issues		
	•	verify that transmission of the			discovered, they will be addre		
	alarm was received	by the monitoring company.			and resolved immediately. Th		
	TEN : C' 1'	. 1 . 1 . 1 . 1			Maintenance Supervisor/desig		
	_	viewed with the Director of			will review with the Administra	itor	
	-	enance Director during the exit			the inspection results.		
	conference on 07/1	1/24.			b The Administrator will		
	2.1.10(1)				monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
	2 D 1 1				Preventative Maintenance		
		review and interview, the			documentation is in place.		
		sure fire drills were held on			4 MONITORING		
		shifts and quarters. This			CORRECTIVE ACTION:		
	_	ould affect all residents in the			a The inspection results w		
	facility.				be presented by the Maintena	nce	
	Findings 1 1 1				Supervisor/designee to the		
	Findings include:				Administrator monthly and the	•	
	D1 ' C	de Celler Co. 19			Administrator will present the		
		the facility's fire drill reports			inspection results at the month	-	
		n 10:15 a.m. and 4:30 p.m. with			Quality Assurance/Performan		
		rector present, there were			Improvement (QA/PI) meeting		
	_	ire drills performed during the			Inspection results and system		
		od and on three occasions			components will be reviewed I	by	
		drills performed on the same			the QA/PI Committee with		
		7/24, and 05/28/24). Based on			subsequent plans of correction		
		e of record review, the			developed and implemented a	as	
		for acknowledged there were			deemed necessary to ensure		
		s documented during the past			compliance is maintained.		
12 month period and there were three occasions		1		This plan of correction			

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

	T OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION G 03	(X3) DATE SURVEY COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		100	EET ADDRESS, CITY, STATE, ZIP COD 2 SISTER BARBARA WAY DRGETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TION (X5) D BE OPRIATE COMPLETION DATE
	same day. This finding was re Nursing and Mainte conference on 07/1	wiewed with the Director of enance Director during the exit 1/24.		constitutes our credible allegation of compliance all regulatory requirement Our date of compliance i 8/16/2024. K914 – Building 01 - It is	nts. s the
	3.1-19(b) 3.1-51(c)			intent of the facility to ensicomplete documentation in available for all non hosp electrical receptacles in all resident room locations are at least annually to meet standards. 1 CORRECTIVE ACTIVE	s ital grade I re tested set IONS designee ctrical the to meet histrator 24.
				a All residents and all and visitors have the pote be affected but none were 3 MEASURES TO PR REOCCURRENCE: a On 8/6/2024 the Administrator in-serviced Maintenance Supervisor/c on the requirement the an electrical receptacle insperand testing must be compannually and documented life safety binder to meet set and order.	staff ntial to e. EVENT the designee nual ection eleted in the

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 03	(X3) DATE SURVEY COMPLETED 07/11/2024
	ROVIDER OR SUPPLIE		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
				b Maintenance Supervisor/designee will the annual electrical rece inspection and testing is completed and document part of the facility's Preve Maintenance Program an document those inspectic as appropriate. If any is discovered, they will be a and resolved immediately Maintenance Supervisor/ will review with the Admin the inspection results. c The Administrator w monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place 4 MONITORING CORRECTIVE ACTION: a The inspection result be presented by the Main Supervisor/designee to the Administrator and the Administrator will present inspection results at the r Quality Assurance/Perfor Improvement (QA/PI) me Inspection results and sy components will be review the QA/PI Committee with subsequent plans of corre developed and implement deemed necessary to end compliance is maintained This plan of correction constitutes our credible allegation of compliance	eted as a entive and con results sues are addressed y. The designee enistrator will see e Its will etenance etenance etenance eting. eting

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 36 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		l í	JILDING	onstruction 03	(X3) DATE COMPL 07/11 /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	·			ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE					
(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)	TE	(X5) COMPLETION DATE
					all regulatory requirements. Our date of compliance is 8/16/2024.		
K 0914 SS=F Bldg. 03	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visic LIM circuits with a manual test is per than or equal to 1. tested per 6.3.3.3 renovation to the Records are main associated repairs	s - Maintenance and ceptacles at patient bed ere deep sedation or general ninistered, are tested after replacement or servicing. is performed at intervals mented performance data. isted as hospital-grade at re tested at intervals not nths. Line isolation monitors are tested at intervals of to 1 month by actuating h per 6.3.2.6.3.6, which ual and audible alarm. For nutomated self-testing, this formed at intervals less 2 months. LIM circuits are .2 after any repair or electric distribution system. stained of required tests and s or modifications, coom or area tested, and					
	interview; the facili documentation was nonhospital-grade e resident room locat NFPA 99, Health C	on, record review and ity failed to ensure complete available for all electrical receptacles in all ions tested at least annually. Care Facilities Code 2012 Edition, ates receptacles not listed as	K 0º	914	K914 – Building 08 - It is the intent of the facility to ensure complete documentation is available for all non hospital gelectrical receptacles in all resident room locations are teat least annually to meet set		08/16/2024

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 37 of 135

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155770	B. W		<u>03</u>	07/11/	
		133770	D. W	_		077117	72024
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED(0.0000000000000000000000000000000000000	UNI THE			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VIN, THE		GEUR	GETOWN, IN 47122		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		atient bed locations and in			standards.	_	
		ep sedation or general istered, shall be tested at			1 CORRECTIVE ACTIONS	5	
		ling 12 months. Additionally,			TAKEN: a On 8/7/2024 the		
		ceptacle Testing in Patient Care			a On 8/7/2024 the Maintenance Supervisor/design	nnoo	
		physical integrity of each			conducted the annual electrication	•	
	_	confirmed by visual inspection.			receptacle inspection and	aı	
	_	ne grounding circuit in each			documented the results in the		
		e shall be verified. Correct			facilities Life safety binder to r		
	_	and neutral connections in			set standards. The Administra		
		ptacle shall be confirmed; and			verified repairs on 8/7/2024.	ator	
		ne grounding blade of each			2 ALL OTHERS WITH		
		e (except locking-type			POTENTAL TO BE AFFECTE	D:	
	_	e not less than 115 grams (4			a All residents and all staf		
		ient practice could affect all			and visitors have the potential		
	residents.	•			be affected but none were.		
					3 MEASURES TO PREVE	NT	
	Findings include:				REOCCURRENCE:		
					a On 8/6/2024 the		
	Based on record rev	view on 07/10/24 between 10:15			Administrator in-serviced the		
	a.m. and 4:30 p.m.	with the Maintenance Director			Maintenance Supervisor/desig	gnee	
	present, there was n	no documentation available of			on the requirement the annua	l	
		room receptacle test for non			electrical receptacle inspection	n	
		ptacles. Based on interview at			and testing must be completed		
		eview, the Maintenance			annually and documented in t	he	
		the electrical receptacles in			life safety binder to meet set		
		e not hospital-grade			standards.		
	-	s he knew. He further said he			b Maintenance		
		mentation to show that annual			Supervisor/designee will ensu		
		9, Receptacle Testing			the annual electrical receptacl	le	
	-	net with all pertinent			inspection and testing is		
		the past 12 month period or			completed and documented a		
		servations on 07/11/24			part of the facility's Preventive)	
		and 12:15 p.m. during a tour of			Maintenance Program and		
	•	Maintenance Director, there			document those inspection re-		
		ectrical receptacles in each			as appropriate. If any issues		
	resident room.				discovered, they will be addre		
	1		- 1		and resolved immediately. The	ıe	I

This finding was reviewed with the Director of

Nursing and Maintenance Director during the exit

Maintenance Supervisor/designee

will review with the Administrator

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	conference on 07/1 3.1-19(b)	1/24.		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 be presented by the Mainter Supervisor/designee to the Administrator and the Administrator will present the inspection results at the mor Quality Assurance/Performa Improvement (QA/PI) meetin Inspection results and syste components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained. This plan of correction constitutes our credible allegation of compliance wall regulatory requirements Our date of compliance is 8/16/2024.	e nthly ince ng. m d by ion d as e
K 0000					
Bldg. 04	Licensure Survey w	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR	K 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission of agreement by this facility of	ot or

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 39 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. W	NG		07/11/	2024
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
\\/\TEDC		/NI THE			ISTER BARBARA WAY GETOWN, IN 47122		
WATERS	OF GEORGETOW	VIN, I IIIE		GEURG	3E I OVVIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					facts alleged, or conclusions	;	
	Facility Number: 0	11509			set forth in this statement of		
	Provider Number:	155770			deficiencies. The plan of		
	AIM Number: 2009	909280			correction and specific		
					corrective actions are prepar	ed	
	-	Code survey, The Waters of			and/or executed in complian	ce	
	Georgetown, 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				with state and federal laws.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	า	
	National Fire Protection Association (NFPA) 101,				all regulatory requirements.		
	Life Safety Code (LSC), and 410 IAC 16.2. Villa 1003 was surveyed with Chapter 19, Existing				Our date of compliance is		
					August 16, 2024. This provid		
	Health Care Occupa	ancies.			respectfully requests that thi	s	
					2567 Plan of Correction be		
		ity was determined to be of			considered the Letter of		
		ruction and fully sprinkled.			Credible Allegation of		
		re alarm system with smoke			Compliance and requests a		
		ridors, spaces open to the			desk review in lieu of a post		
		sident sleeping rooms. The			survey revisit.		
		ty of 10 and had a census of					
	10 at the time of thi	S VISIT.					
	A 11	:14-1					
		idents have customary access					
	services were sprink	all areas providing facility					
	services were spring	kieu.					
	Quality Review con	npleted on 07/16/24					
K 0345	NFPA 101						
SS=F	Fire Alarm System	a - Testing and					
Bldg. 04	Maintenance	1 - 1 county and					
Diag. 07	Fire Alarm System	n - Testing and					
	Maintenance	1 - 1 county and					
		m is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
		n acceptance, maintenance					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 40 of 135

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		JILDING	onstruction 04	(X3) DATE COMPI 07/11	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	on Be PRIATE	(X5) COMPLETION DATE
IAU	and testing are re 9.6.1.3, 9.6.1.5, N 1. Based on record facility failed to end devices connected to performed. NFPA the 2010 Edition, and inspections, testing, provided that include regarding tests and requested in Figure (1) Date (2) Test frequency (3) Name of proper (4) Address (5) Name of person maintenance, tests, affiliation, business number (6) Name, address, approving agency ((7) Designation of to (8) Functional test (9)*Functional test (9)*Functional test (11) Loop resistance line-type heat detect (12) Functional test control units (13) Functional test notification systems (14) Functional test system to silence fr (15) Tests of intellicy system speakers (16) Other tests as a manufacturer's publication.	adily available. IFPA 70, NFPA 72 review and interview, the sure the annual testing of all to 1 of 1 fire alarm system was 72, National Fire Alarm Code, and maintenance shall be desthe following information all the applicable information 14.6.2.4: ty performing inspection, or combination thereof, and address, and telephone and representative of detectors of required sequence of moke detectors of required sequence of the detectors of signal transmission to mass as of ability of mass notification re alarm notification appliances gibility of mass notification required by the equipment required by the equipment	K 0		K345 – Building 8 - It is the intent of the facility to ensure annual testing of all devices connected to fire alarm system in accordance. NFPA 72, as required by LS sections 19.3.4.5.1 and 9.6 ensure complete document available for the sensitivity of all hard wired smoke detand to show what testing instrument is used to test a smoke detectors for sensitive meet set standards. 1 CORRECTIVE ACTION TAKEN: a On 8/9/2024 the facilities Safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the faciliticensed contractor performs semi-annual visual fire alarm system inspection and documented in the facilities Safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the faciliticensed contractor performs semi-annual visual fire alarm system inspection and documented in the facilities Safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards. The Administrative rified the work on 8/9/2024 the facilities safety Binder to meet set standards.	te the stems and fire e with SC 101 stesting ectors. Il wity to DNS ties and the tor 24. 08/16/2024	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. W	ING		07/11/	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN. THE			GETOWN, IN 47122		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		tester and approved authority			results in the Life Safety Binde	er	
	representative	. 11 '11 '10' 11'			and also documented the		
		problems identified during test			manufacturer's calibrated		
	(e.g., system owner				sensitivity test instrument from	1 the	
	corrected/successfully retested, device				fire alarm system inspection	.	
	abandoned in place				contractor to meet set standar		
	_	tice could affect all occupants			The Administrator verified the	work	
	in the facility.				on 8/9/2024.		
	Eindings in sludes				2 ALL OTHERS WITH POTENTIAL TO BE AFFECTI	-D.	
	Findings include:						
	Dasad on record ray	view on 07/10/24 between 10:15					
	Based on record review on 07/10/24 between 10:15				and visitors have the potential be affected but none were.	, to	
	a.m. and 4:30 p.m. with the Maintenance Director present, the facility was unable to provide an					NT	
		ystem inspection/test report			3 MEASURES TO PREVE	:N I	
	·	he past 12 month period. The			REOCCURRENCE:		
	most recent annual				a On 8/6/2024 the		
		ort was dated 06/15/23			Administrator in serviced the		
		acility's fire alarm system			Maintenance Supervisor/desig	-	
		interview at the time of record			on the requirement to ensure		
		nfirmed by the Maintenance			alarm systems are maintained		
	Director.	infilled by the Maintenance			properly including the semi-ar	IIIuai	
	Director.				and annual fire alarm system inspections and testing		
	This finding was re	eviewed with the Director of			documents to be retained in the	20	
		enance Director during the exit			facilities Life Safety Binder an		
	conference on 07/1				ensure the smoke detector	u to	
		1/21.			sensitivity test of all hard wire	d	
	3.1-19(b)				smoke detectors contains the		
	3.1 15(0)				name of the manufacturer's		
	2 Based on record	review and interview, the			calibrated sensitivity test		
		aintain 1 of 1 fire alarm system in			instrument to meet set standa	ırds	
	•	FPA 72, as required by LSC 101			b Maintenance	. 40.	
		and 9.6. NFPA 72, Section			Supervisor/designee will ensu	ıre	
		aless otherwise permitted by			fire alarm systems are mainta		
	14.3.2, visual inspections shall be performed in				properly including the semi-ar		
	accordance with the schedules in Table 14.3.1, or				and annual fire alarm system		
		red by the authority having	inspections and testing				
	-	14.3.1 states that the following	documents to be retained in the				
	T	spected semi-annually:			facilities Life Safety Binder an		
	a. Control unit trou	-			ensure the smoke detector	- to	

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	04	COMPL	ETED
		155770	B. W	ING		07/11/	2024
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	WN THE			GETOWN, IN 47122		
	· · · · · · · · · · · · · · · · · · ·	via, iii		GLOIK	JE 1 OWN, IIV 47 122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY 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
	b. Remote annuncia				sensitivity test of all hard wire		
	_	s (e.g. duct detectors, manual			smoke detectors contains the		
		eat detectors, smoke detectors,			name of the manufacturer's		
	etc.)				calibrated sensitivity test		
	d. Notification appl				instrument as a part of the		
	e. Magnetic hold-open devices				facility's Preventive Maintena		
	_	This deficient practice could affect all residents,			Program and document those		
	staff, and visitors in	staff, and visitors in the facility.			inspection results as appropri		
					If any issues are discovered,	-	
	Findings include:	Findings include:			will be addressed and resolve		
					immediately. The Maintenan		
	Based on record review on 07/10/24 between 10:15				Supervisor/designee will revie	ew	
	a.m. and 4:30 p.m. with the Maintenance Director				with the Administrator the		
	present, there was no documentation provided				inspection results.		
		nnual visual fire alarm system			c The Administrator will		
	-	ne past 12 month period. The			monitor adherence to the		
	I -	em inspection/test provided			Preventative Maintenance		
		for an annual fire alarm			schedule and validate the		
		he facility's vendor. Based on			Preventative Maintenance		
		e of record review, the			documentation is in place.		
		tor confirmed there was no			4 MONITORING		
		inspection of the facility's fire			CORRECTIVE ACTION:		
	1	es performed during the past			a The inspection results v		
	12 month period.				be presented by the Maintena	ance	
	TT : 0" 1"				Supervisor/designee to the		
	_	viewed with the Director of			Administrator and the		
	_	enance Director during the exit			Administrator will present the		
	conference on 07/1	1/24.			inspection results at the mont	-	
	2.1.10(1.)				Quality Assurance/Performan		
	3.1-19(b)				Improvement (QA/PI) meeting	-	
	2 Daged 1	marriage and intermit 41			Inspection results and system		
		review and interview, the			components will be reviewed	by	
		sure complete documentation			the QA/PI Committee with	_	
	was available for the sensitivity testing of all hard				subsequent plans of correction		
	wired smoke detectors, and to show what testing instrument was used to test all smoke detectors		developed and implemented as				
					deemed necessary to ensure		
		PA 72, National Fire Alarm			compliance is maintained.		
		, Section 14.4.5.3.1 states			This plan of correction		
		shall be checked within 1 year every alternate year thereafter.			constitutes our credible		
	i of installation, and	every allernate year increafter.	1		allegation of compliance wit	n	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPLETED
		155770	B. W	ING	_	07/11/2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	8			STER BARBARA WAY	
WATERS	S OF GEORGETOV	VN, THE			GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		quired calibration test, if			all regulatory requirements.	
		icate that the detector has			Our date of compliance is	
		listed and marked sensitivity			8/16/2024.	
	range, the length of time between calibration tests					
	_	shall be permitted to be extended to a maximum of				
		5 years. If the frequency is extended, records of				
		detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In				
		re nuisance alarms show an				
		revious year, calibration tests				
	shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method.					
	1 1	calibrated sensitivity test				
	instrument.	canorated sensitivity test				
		quipment arranged for the				
	purpose.	quipment arranged for the				
		fire alarm control unit				
		by the detector causes a signal				
	_	where its sensitivity is outside				
	its listed sensitivity					
	_	I sensitivity method acceptable				
	to the authority hav	-				
		have sensitivity outside the				
	listed and marked s	ensitivity range shall be				
	cleaned and recalib	rated, or replaced.				
	The detector sensiti	vity cannot be tested or				
	measured using any	spray device that administers				
	an unmeasured con	centration of aerosol into the				
	detector. This defice	cient practice could affect all				
	residents, staff, and	visitors in the facility.				
	Findings include:					
	Based on record rev	view on 07/10/24 between 10:15				
		with the Maintenance Director				
	_	no documentation available to				
	•	ctor sensitivity test of all hard				
		ors has been performed during				

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 44 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>04</u>	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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
		eriod. This was confirmed by rector at the time of record			
	_	viewed with the Director of enance Director during the exit 1/24.			
	3.1-19(b)				
K 0353 SS=F Bldg. 04	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a and readily available. system last checked			
	b) Who provided c) Water system	<u> </u>			
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to proother evidence the shad been inspected for 1 of 1 sprinkler	and NFPA 25 review and interview, the vide written documentation or prinkler system components and tested for 1 of 4 quarters system. LSC 4.6.12.1 requires	K 0353	K353 – Building 08 It is the intof the facility to ensure to provwritten documentation or other evidence the sprinkler system components have been inspec	ide - cted
	compliance with thi accordance with app	ent or system required for s Code be maintained in plicable NFPA requirements. hall be properly maintained in		and tested for 1 of 4 quarters f the sprinkler system and to ensure to document sprinkler system inspections in accorda	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 45 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. WI	NG		07/11/	2024
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	0.0000000000000000000000000000000000000	A/AL THE			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VIN, THE		GEORG	GETOWN, IN 47122		
(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	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with N	FPA 25, Standard for the			with NFPA 25 the dry sprinkle	r	
	Inspection, Testing	, and Maintenance of			system's pressure gauges and		
	Water-Based Fire I	Protection Systems. NFPA 25,			during 10 of the past 12 month		
		rds shall be made for all			for the sprinkler system's cont		
	-	and maintenance of the system			valves to meet set standards.		
	_	all be made available to the			1.CORRECTIVE ACTIONS		
	-	risdiction upon request. 4.3.2			TAKEN:		
		ls shall indicate the procedure			1.On 8/9/2024 the facilitie	es	
	_	spection, test, or maintenance),			licensed sprinkler contractor		
		at performed the work, the			performed the quarterly sprink	ler	
	_	e. NFPA 25, 5.2.5 requires that			inspection and documented th		
		evices shall be inspected			results in the facilities Life Saf		
		they are free of physical			Binder to meet set standards.	,	
		5, 5.3.3.1 requires the mechanical			The Administrator verified the	work	
	_	evices including, but not limited			on 8/9/2024.		
		ngs, shall be tested quarterly.			2.On 7/31/2024 the		
	_	ne-type and pressure			Maintenance Supervisor perfo	rmed	
	_	low alarm devices shall be			the weekly inspection of the		
		y. This deficient practice could			facilities dry sprinkler system		
	_	staff, and visitors in the			gauges and documented the		
	facility.	•			results in the facility life safety		
					binder to meet set standards.		
	Findings include:				Administrator verified the work		
					7/31/2024.		
	Based on review of	f the quarterly sprinkler system			3.On 7/31/2024 the		
	inspection records	on 07/10/24 between 10:15 a.m.			Maintenance Supervisor perfo	rmed	
	and 4:30 p.m. with	the Maintenance Director			the monthly inspection of the		
	present, there was i	no quarterly sprinkler system			facilities sprinkler system cont	rol	
	inspection report a	vailable for the second quarter			valves and documented the re		
	(April, May, and Ju	ine) of 2024. Based on			in the facility life safety binder	to	
	interview at the tim	ne of record review, the			meet set standards. The		
		tor confirmed there was no			Administrator verified the work	con	
	written documentar	tion available to show the			7/31/2024 .		
	sprinkler system ha	ad been inspected during the			2.ALL OTHERS WITH		
	second quarter of 2				POTENTIAL TO BE AFFECTI	ED:	
					1.All residents and all sta	ıff	
	This finding was re	eviewed with the Director of			and visitors have the potential	to	
	_	enance Director during the exit			be affected but none were.		
	conference on 07/1				3.MEASURES TO PREVEN	т	
					REOCCURRENCE:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPLI	ETED
		155770	B. W	ING _		07/11/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN THE			GETOWN, IN 47122		
	1	·	1		J J W. 1, II I I I I I I I I I I I I I I I I I	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY 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
	3.1-19(b)				1.On 8/6/2024 the		
					Administrator in serviced the		
		review, observation, and			Maintenance Supervisor/design	gnee	
		ty failed to document sprinkler			on the requirement to ensure		
	system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 47 of the				sprinkler inspections are		
		-			conducted and documented		
	_	ne sprinkler system's pressure			including the quarterly sprinkle		
		10 of the past 12 months for			inspection, weekly inspection	of	
		n's control valves. NFPA 25,			the gauges and the monthly		
		spection, Testing, and			inspection of the control valve	es to	
		iter-Based Fire Protection			meet set standards.		
	Systems, 2011 Edition, Section 5.2.4.2 states				2.Maintenance		
	gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and				Supervisor/designee will ensu	ıre	
					sprinkler inspections are		
	_	being maintained. Section			conducted and documented		
		and fire department			including the quarterly sprinkle		
		e inspected, tested, and			inspection, weekly inspection	OT	
		rdance with Chapter 13.			the gauges and the monthly		
		ites Table 13.1.1.2 shall be			inspection of the control valve		
	_	on, testing and maintenance of			a part of the facility's Preventi	ve	
	_	onents and trim. Section 4.3.1			Maintenance Program and	14 -	
		be made for all inspections,			document those inspection re		
		nce of the system and its			as appropriate. If any issues		
		all be made available to the risdiction upon request. This			discovered, they will be addre		
		ould affect all residents, staff,			and resolved immediately. The Maintenance Supervisor/design		
	and visitors in the f				will review with the Administra	~	
	and visitors in the I	actificy.				מנטו	
	Findings include:				the inspection results. 3.The Administrator will		
	i maniga merude.				monitor adherence to the		
	a Based on record	review on 07/10/24 between			Preventative Maintenance		
		p.m. with the Maintenance			schedule and validate the		
		ere was no documentation			Preventative Maintenance		
		ne facility's dry sprinkler			documentation is in place.		
		e inspected weekly during 47			4.MONITORING CORRECT	IVF	
		period. The only weekly			ACTION:		
	_	pections were for the weeks in			1.The inspection results	will	
		24. Based on interview at the			be presented by the Maintena		
	1	ew, the Maintenance Director			Supervisor/designee to the	11100	
		s no documentation available			Administrator monthly and the		
	I sommined there wa	o no accamentation available	1		I ranimistrator monthly and the	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024			
	ROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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
IAU	to show that the fact been inspected at let past 52 weeks. Bast 07/11/24 between 9 tour of the facility with facility had two sprinkler riser. b. Based on record 10:15 a.m. and 4:30 Director present, the system control valve for 10 of the past 12 inspections availabl 2024. Based on intereview, the Mainten lack of sprinkler system valves during the part of the past 12 this finding was review, the Mainten lack of sprinkler system control valve the Mainten lack of sprinkler system valves during the part of the past 12 this finding was review.	ility's sprinkler gauges have ast weekly during 47 of the ed on observations on :45 a.m. and 12:15 p.m. during a with the Maintenance Director pressure gauges at the review on 07/10/24 between p.m. with the Maintenance ere was no monthly sprinkler es inspection documentation a months. The only monthly e were for June and July of erview at the time of record tance Director confirmed the stem inspections on the control ast 12 months.		IAU	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 8/16/2024.	e Dy n s	DATE
K 0712 SS=F Bldg. 04	alarm signal and s conditions. Fire dr and unexpected til conditions, at leas The staff is familia aware that drills al routine. Where dr 9:00 PM and 6:00	t quarterly on each shift. Ir with procedures and is Ir part of established Ills are conducted between AM, a coded Instead of					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 48 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPLE	TED
		155770	B. WI	NG		07/11/2	024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATER	S OF GEORGETOV	WN THE			GETOWN, IN 47122		
WAILING	- GLONGLION	VIN, IIIL		GLOIM	3L10WN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
	1. Based on record review and interview, the		K 0	712	K712 – Building 08 - It is the		08/16/2024
	facility failed to provide quarterly fire drill				intent of the facility to ensure	to	
	documentation for 3 of 3 shifts during 3 of 4				provide quarterly fire drill		
	quarters. This deficient practice could affect all				documentation for 3 shifts dur	-	
		s staff and visitors in the			all 4 quarters and to ensure fi		
	facility.				drill reports included complete)	
					documentation of the transmis	ssion	
	Findings include:				of a fire alarm signal to the		
					monitoring company/fire		
		f the facility's fire drill reports			department during the past tw	/elve	
		en 10:15 a.m. and 4:30 p.m. with			months to meet set standards	5.	
		irector present, the facility was			1 CORRECTIVE ACTIONS	S	
		e eight documented fire drill			TAKEN:		
		12 month period. The			a On 8/6/2024 the		
	_	d quarters were missing fire drill			Administrator in-serviced the		
	reports:				Maintenance Supervisor/design	gnee	
	· ·	lay) of the third quarter (July,			on the requirement that fire dr	ills	
	August, and Septer				must be conducted at unexpe	cted	
		t (evening) of the third quarter			times under varying condition	s at	
		September), and fourth quarter			least quarterly on each shift a	nd	
		er, and December) of 2023, and			documented to meet set		
		ry, February, and March) of			standards.		
	2024.				b On 8/6/2024 the		
	·	night) of the third quarter (July,			Administrator in-serviced the		
	August, and Septer				Maintenance Supervisor/desi	gnee	
		at the time of record review,			on the requirement to include		
		irector confirmed the lack of			documentation for the		
		the previously mentioned			transmission of the alarm to the		
	shifts and quarters				monitoring company to meet	set	
					standards.		
	_	eviewed with the Director of			c On 8/6/2024 the		
	_	enance Director during the exit			Administrator in-serviced the		
	conference on 07/11/24.				Maintenance Supervisor/design		
					on the requirement to ensure		
	3.1-19(b)				drills are held on varied dates		
	3.1-51(c)				all shifts and quarters to meet	set	
					standards.		
	2. Based on record review and interview, the				2 ALL OTHERS WITH		
		sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECT		
	included complete	documentation of the			a All residents and all staf	f	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	04	COMPL	ETED
		155770	B. W	ING		07/11/	/2024
		l		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			STER BARBARA WAY		
\\/\TED	OF GEORGETOV	/N THE			GETOWN, IN 47122		
WATERS	OF GEORGETOV	VIN, THE		GEORG	3ETOWN, IN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	transmission of a fire alarm signal to the				and visitors have the potential	to	
	monitoring company/fire department during the				be affected but none were.		
	past twelve months. LSC 19.7.1.4 requires fire				3 MEASURES TO PREVE	NT	
	drills in health care occupancies shall include the				REOCCURRENCE:		
	transmission of the	fire alarm signal and			a Maintenance		
		gency conditions. This			Supervisor/designee will ensu	re	
	deficient practice co	ould affect all residents.			fire drills are conducted at		
					unexpected times under varyi	ng	
	Findings include:				conditions at least quarterly or	n	
					each shift and that documenta	ation	
	Based on review of	the facility's fire drill reports			be retained in the facility's Life)	
	on 07/10/24 betwee	n 10:15 a.m. and 4:30 p.m. with			Safety Binder and all reports v	vill	
	the Maintenance Di	rector present, 3 of 8 fire drill			have documentation for the		
	reports performed of	luring the past 12 month period			transmission of the alarm to th	ne	
	were not provided v	with documentation for the			monitoring company and will		
	transmission of the	alarm to the monitoring			ensure fire drills are held on v	aried	
	company. These dr	rill dates and times include:			dates for all shifts and quarter	s as	
	10/26/23 at 8:00 p.1	m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Preventi	ve	
	at 10:15 p.m. Base	d on interview at the time of			Maintenance Program and		
	record review, the I	Maintenance Director			document those inspection res	sults	
	acknowledged there	e was no information on 3 of 8			as appropriate. If any issues	are	
	fire drill reports to	verify that transmission of the			discovered, they will be addre	ssed	
	alarm was received	by the monitoring company.			and resolved immediately. Th	ie	
					Maintenance Supervisor/desig	gnee	
	This finding was re	viewed with the Director of			will review with the Administra	tor	
	Nursing and Mainte	enance Director during the exit			the inspection results.		
	conference on 07/1	1/24.			b The Administrator will		
					monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
					Preventative Maintenance		
	3. Based on record	review and interview, the			documentation is in place.		
	facility failed to ens	sure fire drills were held on			4 MONITORING		
	varied dates for all shifts and quarters. This				CORRECTIVE ACTION:		
	deficient practice could affect all residents in the				a The inspection results w	ill	
	facility.				be presented by the Maintena	nce	
					Supervisor/designee to the		
	Findings include:				Administrator monthly and the	:	
					Administrator will present the		
	Based on review of	the facility's fire drill reports	1		inenection results at the month	alv	

08/02/2024 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 04 B. WING 07/11/2024 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (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 on 07/10/24 between 10:15 a.m. and 4:30 p.m. with Quality Assurance/Performance the Maintenance Director present, there were Improvement (QA/PI) meeting. eight documented fire drills performed during the Inspection results and system past 12 month period and on three occasions components will be reviewed by there were two fire drills performed on the same the QA/PI Committee with day (10/26/23, 02/27/24, and 05/28/24). Based on subsequent plans of correction interview at the time of record review, the developed and implemented as Maintenance Director acknowledged there were deemed necessary to ensure only eight fire drills documented during the past compliance is maintained. 12 month period and there were three occasions This plan of correction where two fire drills were performed during the constitutes our credible same day. allegation of compliance with all regulatory requirements. This finding was reviewed with the Director of Our date of compliance is Nursing and Maintenance Director during the exit 8/16/2024. conference on 07/11/24. K914 - Building 01 - It is the 3.1-19(b) intent of the facility to ensure 3.1-51(c)complete documentation is available for all non hospital grade electrical receptacles in all resident room locations are tested at least annually to meet set standards. **CORRECTIVE ACTIONS** TAKEN: On 8/7/2024 the Maintenance Supervisor/designee conducted the annual electrical receptacle inspection and documented the results in the facilities Life safety binder to meet set standards. The Administrator verified repairs on 8/7/2024. **ALL OTHERS WITH** POTENTAL TO BE AFFECTED: All residents and all staff and visitors have the potential to

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

Event ID:

OZM221

Facility ID: 011509

be affected but none were.

MEASURES TO PREVENT

If continuation sheet

Page 51 of 135

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>04</u>	(X3) DATE SURVEY COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				REOCCURRENCE: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/des on the requirement the annu electrical receptacle inspecti and testing must be complet annually and documented in life safety binder to meet set standards. b Maintenance Supervisor/designee will ens the annual electrical recepta inspection and testing is completed and documented part of the facility's Preventiv Maintenance Program and document those inspection r as appropriate. If any issue discovered, they will be addr and resolved immediately. T Maintenance Supervisor/des will review with the Administr 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 be presented by the Mainten Supervisor/designee to the Administrator and the Administrator will present the inspection results at the mor Quality Assurance/Performa Improvement (OA/PI) meetir	ignee al on ed the ure cle as a re esults s are essed he ignee rator will ance

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			ILDING	04	COMPL 07/11/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 04	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, recommendational testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch activates both visual LIM circuits with a manual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. s performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not on this. Line isolation monitors hare tested at intervals of to 1 month by actuating to per 6.3.2.6.3.6, which hal and audible alarm. For utomated self-testing, this formed at intervals less months. LIM circuits are 2 after any repair or electric distribution system. trained of required tests and mor modifications,			Inspection 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. Our date of compliance is 8/16/2024.	ı s	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 53 of 135

PRINTED: 08/02/2024 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. BUILDING COMPLETED 04 B. WING 07/11/2024 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and K 0914 08/16/2024 K914 - Building 08 - It is the interview; the facility failed to ensure complete intent of the facility to ensure documentation was available for all complete documentation is nonhospital-grade electrical receptacles in all available for all non hospital grade resident room locations tested at least annually. electrical receptacles in all NFPA 99, Health Care Facilities Code 2012 Edition, resident room locations are tested Section 6.3.4.1.3 states receptacles not listed as at least annually to meet set hospital-grade, at patient bed locations and in standards. locations where deep sedation or general **CORRECTIVE ACTIONS** anesthesia is administered, shall be tested at TAKEN: intervals not exceeding 12 months. Additionally, On 8/7/2024 the Section 6.3.3.2, Receptacle Testing in Patient Care Maintenance Supervisor/designee Rooms requires the physical integrity of each conducted the annual electrical receptacle shall be confirmed by visual inspection. receptacle inspection and The continuity of the grounding circuit in each documented the results in the electrical receptacle shall be verified. Correct facilities Life safety binder to meet polarity of the hot and neutral connections in set standards. The Administrator each electrical receptacle shall be confirmed; and verified repairs on 8/7/2024. retention force of the grounding blade of each **ALL OTHERS WITH** electrical receptacle (except locking-type POTENTAL TO BE AFFECTED: receptacles) shall be not less than 115 grams (4 All residents and all staff ounces). This deficient practice could affect all and visitors have the potential to residents. be affected but none were. MEASURES TO PREVENT Findings include: REOCCURRENCE: On 8/6/2024 the Based on record review on 07/10/24 between 10:15 Administrator in-serviced the a.m. and 4:30 p.m. with the Maintenance Director Maintenance Supervisor/designee present, there was no documentation available of on the requirement the annual an annual resident room receptacle test for non electrical receptacle inspection hospital-grade receptacles. Based on interview at and testing must be completed the time of record review, the Maintenance annually and documented in the Director said all of the electrical receptacles in life safety binder to meet set resident rooms were not hospital-grade standards.

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

receptacles as far as he knew. He further said he

could not find documentation to show that annual

testing per NFPA 99, Receptacle Testing

Event ID:

OZM221

Facility ID: 011509

Maintenance

Supervisor/designee will ensure

the annual electrical receptacle

If continuation sheet

Page 54 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 04	(X3) DATE SUR COMPLETE 07/11/202	D
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP CO SISTER BARBARA WAY GETOWN, IN 47122	DD -	
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION ULLD BE PROPRIATE CO	(X5) OMPLETION DATE
	information within prior. Based on obsetween 9:45 a.m. at the facility with the were at least four elements of the facility with the were facility with the resident room.	net with all pertinent the past 12 month period or servations on 07/11/24 and 12:15 p.m. during a tour of Maintenance Director, there lectrical receptacles in each viewed with the Director of enance Director during the exit 1/24.		inspection and testing is completed and docume part of the facility's Prev Maintenance Program a document those inspect as appropriate. If any i discovered, they will be and resolved immediate Maintenance Supervisor will review with the Admither inspection results. c The Administrator monitor adherence to the Preventative Maintenant schedule and validate the Preventative Maintenant documentation is in place 4 MONITORING CORRECTIVE ACTION a The inspection results at the Administrator will prese inspection results at the Administrator will prese inspection results at the Quality Assurance/Perform Improvement (QA/PI) monitoring Inspection results and so components will be revitable QA/PI Committee we subsequent plans of condeveloped and implement deemed necessary to ecompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirem Our date of compliance 8/16/2024.	nted as a ventive and tion results ssues are addressed ely. The r/designee ninistrator will are accepted and the results will are accepted and the results will and the results will and the results will and the results will are accepted as a results with a rection cented as a rection c	

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 55 of 135

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155770		ľ	JILDING	nstruction 04	(X3) DATE COMPL 07/11 /	ETED	
	PROVIDER OR SUPPLIEF S OF GEORGETOV			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(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)	TE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 04	Electrical Systems System Maintenan The generator or source and assoc of supplying service 10-second criterior monthly test, a pre- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or mani- loads, and are con- personnel. Mainte energy power sou accordance with N circuit breakers ar program for perior components is es- manufacturer requi- of maintenance an and readily availa and circuits are m and separate from Minimizing the po- emergency power consideration for in 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10	other alternate power stated equipment is capable on is not met during the ocess shall be provided to this capability for the life branches. Maintenance generator and transfer ormed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised on the for 4 continuous hours, ander load conditions include ated cold start and utility and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels tarked, readily identifiable, an normal power circuits. ssibility of damage of the resource is a design new installations. (NFPA 99), NFPA 110, 00 (NFPA 70)					
		view and interview, the facility complete written record of	K 0	918	K918 – Building 08 - It is the intent of the facility to ensure	to	08/16/2024

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 56 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ISTER BARBARA WAY		
WATERS	OF GEORGETON	VN, THE		GEOR	GETOWN, IN 47122		
(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 APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oad testing for 1 of 1 generator			maintain a complete written re		
		12 months. Chapter			of monthly generator load tes	ting	
		12 NFPA 99 requires monthly			for generator during the past		
		ator serving the emergency			twelve months to meet set		
	-	be in accordance with NFPA			standards.	_	
		or Emergency and Standby			1 CORRECTIVE ACTION	S	
		hapter 8. Chapter 6.4.4.2 of			TAKEN:		
	-	written record of inspection,			a On 7/15/2024 the		
	*	ising period, and repairs for the slarly maintained and available			Maintenance Supervisor conducted the monthly load		
	for inspection by th	-			<u> </u>		
		er 6-4.4.1.3 of 2012 NFPA 99			testing for the emergency generator and documented the		
		or on-site generators shall be			1 *		
	-	dance with NFPA 110, 2010			results in the facilities Life Sa Binder to meet set standards.	•	
		or Emergency and Standby			The Administrator verified the		
		3.7 requires storage batteries,			on 7/15/2024.	WOIK	
		e levels or battery voltage,			2 ALL OTHERS WITH		
		with systems shall be			POTENTIAL TO BE AFFECT	ED.	
		nd maintained in full			a All residents and all state		
		anufacturer's specifications.			and visitors have the potentia		
	-	tive batteries shall be repaired			be affected but none were.	110	
		ately upon discovery of			3 MEASURES TO PREVE	NT	
	-	5.4.2 of NFPA 99 requires a			REOCCURRENCE:	-141	
	-	spection, performance,			a On 8/6/2024 the		
		nd repairs shall be regularly			Administrator in-serviced the		
		ilable for inspection by the			Maintenance Supervisor/desi	gnee	
		risdiction. This deficient			on the requirement to conduc	-	
		t all residents, staff and			testing on the emergency		
	visitors.				generator including the month	nly	
					testing to meet set standards	•	
	Findings include:				b The Maintenance		
					Supervisor/designee will ensu	ire to	
	Based on review of	the generator inspection and			conduct all testing on the		
	testing reports on 0'	7/10/24 between 10:15 a.m. and			emergency generator includir	ng the	
	•	Maintenance Director present,			monthly load testing as a part	of	
		ly generator load test			the facility's Preventive		
		lable for June of 2024 for the			Maintenance Program and		
		or. Based on interview at the			document those inspection re	sults	
		ew, the Maintenance Director			as appropriate. If any issues	are	
	said the facility has	been in a transition period	ı		discovered they will be addre	secod	l

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

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVI	EΥ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	04	COMPLETED	
		155770	B. WI	NG		07/11/2024	•
	PROVIDER OR SUPPLIER			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(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 CROSS-REFERENCED TO THE APPROPRIA	COM	(PLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE I	DATE
		o and the monthly load test of			and resolved immediately. Th		
		erator was not completed.			Maintenance Supervisor/desig		
	and emergency generator was not compressed.				will review with the Administra		
This finding was reviewed with the Director of				the inspection results.			
	Nursing and Maintenance Director during the exit				c The Administrator will		
	conference on 07/1	_			monitor adherence to the		
					Preventative Maintenance		
	3.1-19(b)				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	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the montl	nly	
					Quality Assurance/Performan	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	ру	
					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		
					allegation of compliance with	ו	
					all regulatory requirements.		
					Our date of compliance is		
					8/16/2024.		
K 0000							
Bldg. 05							
J. 22	A Life Safety Code	Recertification and State	K 00	000	Preparation and/or execution	,	
	-	as conducted by the Indiana	12.00		of this plan of correction in		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	05	COMPL	ETED
		155770	B. W	ING		07/11/	2024
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
\\/\TED(VAL TUE		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
WAIERS	S OF GEORGETOV	VIN, I FIE		GEORG	3E 1000N, IN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Department of Heal	Ith in accordance with 42 CFR			general, or this corrective		
	483.90(a). Survey Dates: 07/10/24 and 07/11/24				action in particular does not		
					constitute and admission or		
					agreement by this facility of	the	
					facts alleged, or conclusions	;	
	Facility Number: 0				set forth in this statement of		
	Provider Number:	155770			deficiencies. The plan of		
	AIM Number: 200	909280			correction and specific		
					corrective actions are prepar		
		Code survey, The Waters of			and/or executed in complian	ce	
		ound not in compliance with			with state and federal laws.		
	Requirements for P				This plan of correction		
		l, 42 CFR Subpart 483.90(a),			constitutes our credible		
	1	re and the 2012 edition of the			allegation of compliance witl	า	
		ction Association (NFPA) 101,			all regulatory requirements.		
		LSC), and 410 IAC 16.2. Villa			Our date of compliance is		
		with Chapter 19, Existing			August 16, 2024. This provid		
	Health Care Occupa	ancies.			respectfully requests that thi	is	
					2567 Plan of Correction be		
	1	ity was determined to be of			considered the Letter of		
	` ` '	ruction and fully sprinkled.			Credible Allegation of		
		re alarm system with smoke			Compliance and requests a		
		ridors, spaces open to the			desk review in lieu of a post		
		esident sleeping rooms. The			survey revisit.		
	at the time of this v	ity of 10 and had a census of 9					
	at the time of this v	isit.					
	All grage where res	idents have customary access					
		all areas providing facility					
	services were sprin						
	services were spring	Ricu.					
	Quality Review cor	mpleted on 07/16/24					
	Quality Review con	inpleted on 07/10/21					
K 0345	NFPA 101						
SS=F	Fire Alarm Systen	n - Testing and					
Bldg. 05	Maintenance	3					
-	Fire Alarm Systen	n - Testing and					
	Maintenance	3					
		m is tested and maintained					
		h an approved program					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 59 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	05	COMPL	
		155770	B. W	ING		07/11	/2024
NAME OF T	DROWNER OF CURPLYER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	(1002 S	ISTER BARBARA WAY		
WATERS	OF GEORGETOV	VN, THE		GEORG	GETOWN, IN 47122		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		e requirements of NFPA 70,					
		Code, and NFPA 72, m and Signaling Code.					
		n acceptance, maintenance					
	and testing are rea						
	_	FPA 70, NFPA 72					
		review and interview, the	K 0	345	K345 – Building 8 - It is the		08/16/2024
		sure the annual testing of all		J 1J	intent of the facility to ensure t	he	30/10/2027
	1	to 1 of 1 fire alarm system was			annual testing of all devices		
		72, National Fire Alarm Code,			connected to fire alarm system	าร	
	the 2010 Edition, at	14.6.2.4 requires a record of all			are performed and to maintain		
	inspections, testing,	, and maintenance shall be			alarm system in accordance w	/ith	
	provided that include	des the following information			NFPA 72, as required by LSC		
	regarding tests and	all the applicable information			Sections 19.3.4.5.1 and 9.6 ar	nd to	
	requested in Figure	14.6.2.4:			ensure complete documentation	on is	
	(1) Date				available for the sensitivity tes	ting	
	(2) Test frequency				of all hard wired smoke detect	ors	
	(3) Name of proper	ty			and to show what testing		
	(4) Address				instrument is used to test all		
		performing inspection,			smoke detectors for sensitivity	to to	
		or combination thereof, and			meet set standards.		
		address, and telephone			1 CORRECTIVE ACTIONS	3	
	number				TAKEN:		
		and representative of			a On 8/9/2024 the facilities		
	approving agency (licensed contractor performed	the	
		the detector(s) tested			annual fire alarm system		
	(8) Functional test				inspection / test report and documented in the facilities Li	-	
		of required sequence of				ie	
	operations (10) Check of all sn	noke detectors			Safety Binder to meet set standards. The Administrator		
	' '	e for all fixed-temperature,			verified the work on 8/9/2024.		
	line-type heat detec	-			b On 8/9/2024 the facilities	2	
		of mass notification system			licensed contractor performed		
	control units				semi-annual visual fire alarm		
	(13) Functional test of signal transmission to mass				system inspection and		
	(13) Functional test of signal transmission to mass notification systems				documented in the facilities Li	fe	
	_	of ability of mass notification			Safety Binder to meet set		
		re alarm notification appliances			standards. The Administrator		
		gibility of mass notification			verified the work on 8/9/2024.		
	system speakers	-			c On 8/9/2024 the facilities	:	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 05			(X3) DATE SURVEY COMPLETED	
		155770	B. W	ING		07/11/	/2024
	PROVIDER OR SUPPLIER		<u> </u>	1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	(16) Other tests as a	required by the equipment			license contractor performed	the	
	manufacturer's pub	lished instructions			biannual sensitivity testing on	the	
	(17) Other tests as a	required by the authority			fire alarm system smoke		
	having jurisdiction				detectors and documented the	е	
	(18) Signatures of t	ester and approved authority			results in the Life Safety Binde	er	
	representative				and also documented the		
	(19) Disposition of	problems identified during test			manufacturer's calibrated		
	(e.g., system owner	notified, problem			sensitivity test instrument fron	n the	
	corrected/successfu	lly retested, device			fire alarm system inspection		
	abandoned in place)			contractor to meet set standar	rds.	
	This deficient pract	ice could affect all occupants			The Administrator verified the	work	
	in the facility.				on 8/9/2024.		
					2 ALL OTHERS WITH		
	Findings include:				POTENTIAL TO BE AFFECT	ED:	
					a All residents and all staf	f	
	Based on record rev	view on 07/10/24 between 10:15			and visitors have the potential	l to	
	a.m. and 4:30 p.m.	with the Maintenance Director			be affected but none were.		
	present, the facility	was unable to provide an			3 MEASURES TO PREVE	ENT	
	annual fire alarm sy	stem inspection/test report			REOCCURRENCE:		
	performed during th	ne past 12 month period. The			a On 8/6/2024 the		
	most recent annual	fire alarm system			Administrator in serviced the		
	inspection/test repo	rt was dated 06/15/23			Maintenance Supervisor/desi	gnee	
	performed by the fa	cility's fire alarm system			on the requirement to ensure	fire	
	vendor. Based on i	nterview at the time of record			alarm systems are maintained	t	
	review, this was con	nfirmed by the Maintenance			properly including the semi-ar	nnual	
	Director.				and annual fire alarm system		
					inspections and testing		
	This finding was re	viewed with the Director of			documents to be retained in the	he	
	Nursing and Mainte	enance Director during the exit			facilities Life Safety Binder an	d to	
	conference on 07/1	1/24.			ensure the smoke detector		
					sensitivity test of all hard wire	d	
3.1-19(b)				smoke detectors contains the			
				name of the manufacturer's			
2. Based on record review and interview, the				calibrated sensitivity test			
facility failed to maintain 1 of 1 fire alarm system in				instrument to meet set standa	ırds.		
accordance with NFPA 72, as required by LSC 101				b Maintenance			
Sections 19.3.4.5.1 and 9.6. NFPA 72, Section				Supervisor/designee will ensu	ıre		
14.3.1 states that unless otherwise permitted by				fire alarm systems are mainta			
	14.3.2, visual inspe	ctions shall be performed in			properly including the semi-ar		
	accordance with the	e schedules in Table 14.3.1, or			and annual fire alarm system		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>05</u>	COMPLE	ETED	
		155770	B. W	ING		07/11/2	2024	
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
\\/ATED		VAL THE			ISTER BARBARA WAY			
WATERS	S OF GEORGETOV	VIN, THE		GEORG	GETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
	more often if required by the authority having				inspections and testing			
	jurisdiction. Table	14.3.1 states that the following			documents to be retained in th	ne		
	must be visually ins	spected semi-annually:			facilities Life Safety Binder and	d to		
	a. Control unit trouble signals				ensure the smoke detector			
	b. Remote annuncia	ators			sensitivity test of all hard wired	d l		
	c. Initiating devices	(e.g. duct detectors, manual			smoke detectors contains the			
	fire alarm boxes, he	eat detectors, smoke detectors,			name of the manufacturer's			
	etc.)				calibrated sensitivity test			
	d. Notification appl	iances			instrument as a part of the			
	e. Magnetic hold-op	pen devices			facility's Preventive Maintenar	nce		
	This deficient pract	ice could affect all residents,			Program and document those			
	staff, and visitors in	the facility.			inspection results as appropria			
					If any issues are discovered, t			
	Findings include:				will be addressed and resolve	-		
					immediately. The Maintenanc	e l		
	Based on record rev	view on 07/10/24 between 10:15			Supervisor/designee will revie	w		
	a.m. and 4:30 p.m.	with the Maintenance Director			with the Administrator the			
	present, there was r	no documentation provided			inspection results.			
	regarding a semi-ar	nnual visual fire alarm system			c The Administrator will			
	inspection during th	ne past 12 month period. The			monitor adherence to the			
	only fire alarm syst	em inspection/test provided			Preventative Maintenance			
	was dated 06/15/23	for an annual fire alarm			schedule and validate the			
	inspection/test by the	ne facility's vendor. Based on			Preventative Maintenance			
	interview at the tim	e of record review, the			documentation is in place.			
	Maintenance Direct	tor confirmed there was no			4 MONITORING			
	semi-annual visual	inspection of the facility's fire			CORRECTIVE ACTION:			
	alarm system devic	es performed during the past			a The inspection results w	ill		
	12 month period.				be presented by the Maintena	nce		
					Supervisor/designee to the			
	This finding was re	viewed with the Director of			Administrator and the			
	Nursing and Mainte	enance Director during the exit			Administrator will present the			
	conference on 07/1	1/24.			inspection results at the month	nly		
					Quality Assurance/Performand	ce		
	3.1-19(b)				Improvement (QA/PI) meeting			
					Inspection results and system			
	3. Based on record	review and interview, the			components will be reviewed by	оу		
	facility failed to ens	sure complete documentation			the QA/PI Committee with			
	was available for th	e sensitivity testing of all hard			subsequent plans of correction			
	wired smoke detect	ors, and to show what testing			developed and implemented a	ıs		
	instrument was use	d to test all smoke detectors			deemed necessary to ensure			

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE : COMPL 07/11 /	ETED
	PROVIDER OR SUPPLIER	-		1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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)	TE	(X5) COMPLETION DATE
TAG	for sensitivity. NFI Code, 2010 Edition detector sensitivity of installation, and a After the second recessensitivity tests indi- remained within its range, the length of shall be permitted to 5 years. If the frequency detector caused nuitarends of these alarn zones or areas where increase over the propose of the shall be performed. detector is within its range, it shall be test (1) Calibrated test r (2) Manufacturer's of instrument. (3) Listed control expurpose. (4) Smoke detector arrangement wherea at the control unit with its listed sensitivity (5) Other calibrated to the authority hav Detectors found to b listed and marked s cleaned and recalib. The detector sensiti measured using any an unmeasured con- detector. This defice	PA 72, National Fire Alarm , Section 14.4.5.3.1 states shall be checked within 1 year every alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity 'time between calibration tests to be extended to a maximum of the ency is extended, records of sance alarms and subsequent ms shall be maintained. In the nuisance alarms show an revious year, calibration tests To ensure that each smoke as listed and marked sensitivity sted using any of the methods: method. calibrated sensitivity test quipment arranged for the 'fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be		TAG	compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/16/2024.		DATE
		view on 07/10/24 between 10:15					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 63 of 135

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A			LDING	nstruction <u>05</u>	(X3) DATE : COMPL 07/11 /	ETED	
	PROVIDER OR SUPPLIER			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		_
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
K 0353 SS=F Bldg. 05	a.m. and 4:30 p.m. present, there was deshow a smoke detect by the facility's fire vendor, however, the name of the manufatest instrument. The Maintenance Direct This finding was resulted by the facility's fire vendor, however, the name of the manufatest instrument. The Maintenance Direct This finding was resulted by the facility's fire vendor, however, the name of the manufatest instrument. The Maintenance Direct This finding was resulted by the	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. It system last checked I system test Supply source RKS information on Inon-required or partial er system.	K 03	TAG	K353 – Building 08 It is the in of the facility to ensure to prov written documentation or other	ide	08/16/2024

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 64 of 135

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	05	COMPI	LETED
		155770	B. W	B. WING		07/11	/2024
		1					-
NAME OF	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
TO HAIL OF	I KO VIDEK OK SOITEIEI			1002 S	ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE		GEOR	GETOWN, IN 47122		
(VA) ID	CURALANY	GTATEMENT OF DEFICIENCIE	1	ID.	T		(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY 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
	•	and tested for 1 of 4 quarters			evidence the sprinkler system		
	for 1 of 1 sprinkler	system. LSC 4.6.12.1 requires			components have been inspe	cted	
	any device, equipm	ent or system required for			and tested for 1 of 4 quarters	for	
	compliance with th	is Code be maintained in			the sprinkler system and to		
	accordance with ap	plicable NFPA requirements.			ensure to document sprinkler		
	Sprinkler systems s	shall be properly maintained in			system inspections in accorda	ance	
	accordance with NI	FPA 25, Standard for the			with NFPA 25 the dry sprinkle		
		, and Maintenance of			system's pressure gauges an		
		Protection Systems. NFPA 25,			during 10 of the past 12 mont		
		ds shall be made for all			for the sprinkler system's con		
	_	nd maintenance of the system			valves to meet set standards.		
	_	all be made available to the			1.CORRECTIVE ACTIONS		
		risdiction upon request. 4.3.2			TAKEN:		
		s shall indicate the procedure			1.On 8/9/2024 the faciliti	A S	
	_	spection, test, or maintenance),	licensed sprinkler contractor		03		
		at performed the work, the			performed the quarterly sprint	dor	
	_	e. NFPA 25, 5.2.5 requires that			1		
		evices shall be inspected			inspection and documented the		
		-			results in the facilities Life Sa	-	
		they are free of physical			Binder to meet set standards.		
	_	, 5.3.3.1 requires the mechanical			The Administrator verified the	work	
		vices including, but not limited			on 8/9/2024.		
	_	ngs, shall be tested quarterly.			2.On 7/31/2024 the		
	_	ne-type and pressure			Maintenance Supervisor perfo	ormed	
		ow alarm devices shall be			the weekly inspection of the		
	1	7. This deficient practice could			facilities dry sprinkler system		
	· ·	staff, and visitors in the			gauges and documented the		
	facility.				results in the facility life safety	1	
					binder to meet set standards.	The	
	Findings include:				Administrator verified the wor	k on	
					7/31/2024.		
	Based on review of	the quarterly sprinkler system			3.On 7/31/2024 the		
	inspection records	on 07/10/24 between 10:15 a.m.			Maintenance Supervisor perfo	ormed	
	and 4:30 p.m. with	the Maintenance Director			the monthly inspection of the		
	_	no quarterly sprinkler system			facilities sprinkler system con	trol	
		vailable for the second quarter			valves and documented the re		
		nne) of 2024. Based on			in the facility life safety binder		
		e of record review, the			meet set standards. The		
		tor confirmed there was no			Administrator verified the wor	k on	
		ion available to show the			7/31/2024 .	011	
					1 . , 5 ! / £ 5 £ ! .		1

sprinkler system had been inspected during the

2.ALL OTHERS WITH

PRINTED: 08/02/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>05</u>			ETED	
		155770	B. W	NG		07/11/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			l	ISTER BARBARA WAY				
WATERS	WATERS OF GEORGETOWN, THE			GEORGETOWN, IN 47122				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)				DATE	
	second quarter of 2024.				POTENTIAL TO BE AFFECTE	ED:		
					1.All residents and all sta	ıff		
	_	viewed with the Director of			and visitors have the potential	to		
	Nursing and Mainto	enance Director during the exit			be affected but none were.			
	conference on 07/1	1/24.			3.MEASURES TO PREVEN	Т		
					REOCCURRENCE:			
	3.1-19(b)				1.On 8/6/2024 the			
					Administrator in serviced the			
	Based on record	review, observation, and			Maintenance Supervisor/design	gnee		
	interview; the facili	ity failed to document sprinkler			on the requirement to ensure			
	system inspections	in accordance with NFPA 25		sprinkler inspections are				
	for 1 of 1 dry sprin	kler system during 47 of the			conducted and documented			
	past 52 weeks for the	he sprinkler system's pressure			including the quarterly sprinkle	er		
	gauges, and during	10 of the past 12 months for		inspection, weekly inspection of				
	the sprinkler systen	n's control valves. NFPA 25,		the gauges and the monthly				
	Standard for the Ins	spection, Testing, and		inspection of the control valves to				
	Maintenance of Wa	nter-Based Fire Protection			meet set standards.			
	Systems, 2011 Edit	ion, Section 5.2.4.2 states			2.Maintenance			
	gauges on dry pipe	sprinkler systems shall be			Supervisor/designee will ensu	re		
	inspected weekly to	ensure that normal air and			sprinkler inspections are			
	water pressures are	being maintained. Section			conducted and documented			
	5.1.2 states valves a	and fire department			including the quarterly sprinkle	er		
	connections shall b	e inspected, tested, and			inspection, weekly inspection	of		
	maintained in accor	rdance with Chapter 13.			the gauges and the monthly			
	Section 13.1.1.2 sta	ates Table 13.1.1.2 shall be			inspection of the control valve	s as		
	utilized for inspecti	on, testing and maintenance of			a part of the facility's Preventi	ve		
	valves, valve comp	onents and trim. Section 4.3.1			Maintenance Program and			
	states records shall	be made for all inspections,			document those inspection res	sults		
	tests, and maintena	nce of the system and its			as appropriate. If any issues	are		
	components and sh	all be made available to the			discovered, they will be addre			
		risdiction upon request. This			and resolved immediately. Th			
	deficient practice c	ould affect all residents, staff,			Maintenance Supervisor/desig			
	and visitors in the f				will review with the Administra	-		
					the inspection results.			
	Findings include:				3.The Administrator will			
	_				monitor adherence to the			
	a. Based on record	review on 07/10/24 between			Preventative Maintenance			
10:15 a.m. and 4:30 p.m. with the Maintenance				schedule and validate the				

Director present, there was no documentation

available to show the facility's dry sprinkler

OZM221

Preventative Maintenance

documentation is in place.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 05 COMPLETED B. WING 07/11/2024				
		155770	B. W	ING		07/11/	2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	system gauges were of the past 52 week sprinkler gauge insp June and July of 20 time of record revie confirmed there was to show that the fac been inspected at le past 52 weeks. Bas 07/11/24 between 9 tour of the facility with the facility had two sprinkler riser. b. Based on record 10:15 a.m. and 4:30 Director present, the system control valve for 10 of the past 12 inspections available 2024. Based on intereview, the Maintenlack of sprinkler systems was during the past 12. This finding was record the past 12 to 12 to 13 to 14 to 15	e inspected weekly during 47 period. The only weekly pections were for the weeks in 24. Based on interview at the w, the Maintenance Director is no documentation available illity's sprinkler gauges have ast weekly during 47 of the ed on observations on :45 a.m. and 12:15 p.m. during a with the Maintenance Director pressure gauges at the review on 07/10/24 between p.m. with the Maintenance ere was no monthly sprinkler es inspection documentation months. The only monthly e were for June and July of erview at the time of record hance Director confirmed the stem inspections on the control		TAG	4.MONITORING CORRECTION: 1.The inspection results to 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 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 8/16/2024.	ve will nnce hly ce by	DATE
	conference on 07/11 3.1-19(b)						
K 0712 SS=F Bldg. 05	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 05 COMPLETED B. WING 07/11/202				LETED	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	routine. Where di 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1. Based on record facility failed to producementation for 2 quarters. This defice residents, as well as facility. Findings include: Based on review of on 07/10/24 betwee the Maintenance Di only able to provide reports for the past following shifts and reports: a. The first shift (d. August, and Septents). The second shift (July, August, and (October, November first quarter (Januar 2024. c. The third shift (r. August, and Septents) and Septents and Quarters This finding was resulted.	ay be used instead of 19.7.1.7 review and interview, the ovide quarterly fire drill 3 of 3 shifts during 3 of 4 cient practice could affect all 5 staff and visitors in the The facility's fire drill reports on 10:15 a.m. and 4:30 p.m. with frector present, the facility was the eight documented fire drill 12 month period. The 14 quarters were missing fire drill ay) of the third quarter (July, fiber) of 2023. (evening) of the third quarter for, and December) of 2023, and for, February, and March) of fight) of the third quarter (July, fiber) of 2023. at the time of record review, frector confirmed the lack of the previously mentioned viewed with the Director of enance Director during the exit	K 0	712	K712 – Building 08 - It is the intent of the facility to ensure provide quarterly fire drill documentation for 3 shifts durall 4 quarters and to ensure fidrill reports included complete documentation of the transmis of a fire alarm signal to the monitoring company/fire department during the past two months to meet set standards 1 CORRECTIVE ACTIONSTAKEN: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement that fire dramst be conducted at unexpetimes under varying condition least quarterly on each shift a documented to meet set standards. b On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement to include documentation for the transmission of the alarm to the monitoring company to meet standards. c On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design the requirement to ensure standards.	to ring re e ssion velve s. S gnee rills ected s at and gnee	08/16/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>05</u>		05	COMPLETED	
		155770	B. W	ING		07/11/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ISTER BARBARA WAY		
WATERS	OF GEORGETOV	VN, THE		GEORGETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				drills are held on varied dates for		
	3.1-51(c)				all shifts and quarters to mee	t set	
					standards.		
		review and interview, the			2 ALL OTHERS WITH		
	_	sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECT	ED:	
	_	documentation of the			a All residents and all sta	ff	
		re alarm signal to the			and visitors have the potentia	l to	
		y/fire department during the			be affected but none were.		
	_	. LSC 19.7.1.4 requires fire			3 MEASURES TO PREVI	ENT	
	drills in health care occupancies shall include the				REOCCURRENCE:		
	transmission of the fire alarm signal and				a Maintenance		
	simulation of emergency conditions. This			Supervisor/designee will ensure		ıre	
	deficient practice could affect all residents.			fire drills are conducted at			
					unexpected times under vary	ing	
	Findings include:				conditions at least quarterly of	n	
					each shift and that document	ation	
		the facility's fire drill reports			be retained in the facility's Lif	е	
		en 10:15 a.m. and 4:30 p.m. with			Safety Binder and all reports	will	
		irector present, 3 of 8 fire drill			have documentation for the		
		luring the past 12 month period			transmission of the alarm to t	he	
	-	with documentation for the			monitoring company and will		
		alarm to the monitoring			ensure fire drills are held on v	/aried	
		rill dates and times include:			dates for all shifts and quarte	rs as	
	_	m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Prevent	ive	
	_	d on interview at the time of			Maintenance Program and		
	·	Maintenance Director			document those inspection re	sults	
	_	e was no information on 3 of 8			as appropriate. If any issues		
	_	verify that transmission of the			discovered, they will be addre		
	alarm was received	by the monitoring company.			and resolved immediately. T		
					Maintenance Supervisor/desi	gnee	
	_	viewed with the Director of			will review with the Administra	ator	
	_	enance Director during the exit			the inspection results.		
	conference on 07/1	1/24.			b The Administrator will		
					monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
					Preventative Maintenance		
		review and interview, the			documentation is in place.		
	-	sure fire drills were held on			4 MONITORING		
varied dates for all shifts and quarters. This		1		CORRECTIVE ACTION:			

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 69 of 135

ì ´		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>05</u> COMPLETED 07/11/2024				
		155770	B. W	ING		07/11/2	2024
NAME OF F	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD	_	
\\\\		/NI TUE	1002 SISTER BARBARA WAY				
WATERS	OF GEORGETOV	vin, i⊓⊑		GEORG	GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		:11	DATE
deficient practice could affect all residents in the facility.				a The inspection results w be presented by the Maintena			
	lacility.				Supervisor/designee to the	lice	
	Findings include:				Administrator monthly and the		
	8				Administrator will present the		
	Based on review of	the facility's fire drill reports			inspection results at the month	nly	
	on 07/10/24 betwee	n 10:15 a.m. and 4:30 p.m. with			Quality Assurance/Performand	ce	
	the Maintenance Di	rector present, there were			Improvement (QA/PI) meeting		
	_	ire drills performed during the			Inspection results and system		
		od and on three occasions			components will be reviewed I	by	
		drills performed on the same			the QA/PI Committee with		
		7/24, and 05/28/24). Based on			subsequent plans of correction		
		e of record review, the			developed and implemented a	ıs	
		for acknowledged there were			deemed necessary to ensure		
		d there were three occasions	compliance is maintained.				
		s were performed during the		This plan of correction constitutes our credible			
	same day.	s were performed during the			allegation of compliance with	h	
	sume day.				all regulatory requirements.		
	This finding was re	viewed with the Director of			Our date of compliance is		
	_	enance Director during the exit			8/16/2024.		
	conference on 07/1	1/24.					
					K914 – Building 01 - It is the		
	3.1-19(b)				intent of the facility to ensure		
	3.1-51(c)				complete documentation is		
					available for all non hospital g	grade	
					electrical receptacles in all		
					resident room locations are te	sted	
					at least annually to meet set		
					standards.		
					1 CORRECTIVE ACTIONS TAKEN:	•	
					a On 8/7/2024 the		
					Maintenance Supervisor/design	nnee	
					conducted the annual electrical		
					receptacle inspection and	<u> </u>	
					documented the results in the		
					facilities Life safety binder to r		
					set standards. The Administra		
				verified repairs on 8/7/2024			

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 05 B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024	
	ROVIDER OR SUPPLIE		1002 \$	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				2 ALL OTHERS WITH POTENTAL TO BE AFFECTE a All residents and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVE REOCCURRENCE: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement the annual electrical receptacle inspection and testing must be complete annually and documented in the life safety binder to meet set standards. b Maintenance Supervisor/designee will ensu the annual electrical receptact inspection and testing is completed and documented at part of the facility's 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 Administration 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 were sented by the Maintenance	ED: If I to ENT gnee I n d he ure le us a e sults are essed he gnee ator

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 71 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>05</u>	(X3) DATE SURVEY COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP C SISTER BARBARA WAY GETOWN, IN 47122	COD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE
K 0914 SS=F Bldg. 05	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visit	s - Maintenance and s - Maintenance and ceptacles at patient bed are deep sedation or general ainistered, are tested after areplacement or servicing. ais performed at intervals anted performance data. asted as hospital-grade at a tested at intervals not atths. Line isolation monitors are tested at intervals of to 1 month by actuating an per 6.3.2.6.3.6, which ual and audible alarm. For utomated self-testing, this		Supervisor/designee to Administrator and the Administrator and the Administrator will press inspection results at the Quality Assurance/Per Improvement (QA/PI) Inspection results and components will be reverthe QA/PI Committee to subsequent plans of codeveloped and implement deemed necessary to compliance is maintain. This plan of correction constitutes our credital allegation of compliantal regulatory requires Our date of compliance 8/16/2024.	ent the le monthly formance meeting. system viewed by with borrection mented as ensure med. in ble ince with ments.

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 72 of 135

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	05	COMPL	ETED
		155770	B. W	NG		07/11/	/2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY		
WATED!	S OF GEORGETOV	VNI THE			GETOWN, IN 47122		
WATER	5 OF GEORGETOV	VIN, I TIE		GEORG	3E 1 O WIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	manual test is per	formed at intervals less					
	than or equal to 1	2 months. LIM circuits are					
	tested per 6.3.3.3.2 after any repair or						
	renovation to the	electric distribution system.					
	Records are main	tained of required tests and					
	associated repairs	s or modifications,					
	containing date, re	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
		on, record review and	K 0	914	K914 – Building 08 - It is the		08/16/2024
		ity failed to ensure complete			intent of the facility to ensure		
	documentation was				complete documentation is		
		electrical receptacles in all			available for all non hospital of	jrade	
		ions tested at least annually.			electrical receptacles in all		
		Care Facilities Code 2012 Edition,			resident room locations are te	sted	
		ates receptacles not listed as			at least annually to meet set		
		atient bed locations and in			standards.		
		ep sedation or general			1 CORRECTIVE ACTIONS	3	
		istered, shall be tested at			TAKEN:		
		ding 12 months. Additionally,			a On 8/7/2024 the		
		ceptacle Testing in Patient Care			Maintenance Supervisor/desig	jnee	
	_	physical integrity of each			conducted the annual electrica	al	
	_	confirmed by visual inspection.			receptacle inspection and		
	_	ne grounding circuit in each			documented the results in the		
	_	e shall be verified. Correct			facilities Life safety binder to r	neet	
		and neutral connections in			set standards. The Administra	ator	
		ptacle shall be confirmed; and			verified repairs on 8/7/2024.		
		ne grounding blade of each			2 ALL OTHERS WITH		
	_	e (except locking-type			POTENTAL TO BE AFFECTE	.D:	
	- '	e not less than 115 grams (4			a All residents and all staff		
	*	ient practice could affect all			and visitors have the potential	to	
	residents.				be affected but none were.		
					3 MEASURES TO PREVE	NT	
	Findings include:				REOCCURRENCE:		
					a On 8/6/2024 the		
		view on 07/10/24 between 10:15			Administrator in-serviced the		
	_	with the Maintenance Director			Maintenance Supervisor/desig	-	
	_	no documentation available of			on the requirement the annual		
		room receptacle test for non			electrical receptacle inspection		
	hospital-grade rece	ptacles. Based on interview at			and testing must be completed	b	

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 73 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	05	COMPL	ETED
		155770	B. WI	NG		07/11/	2024
			_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN. THE			GETOWN, IN 47122		
	ı	·			1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		eview, the Maintenance			annually and documented in the	he	
	Director said all of the electrical receptacles in				life safety binder to meet set		
	resident rooms were not hospital-grade				standards.		
	receptacles as far as he knew. He further said he could not find documentation to show that annual				b Maintenance		
		9, Receptacle Testing			Supervisor/designee will ensu		
		net with all pertinent			the annual electrical receptacl	е	
	_	the past 12 month period or			inspection and testing is		
		servations on 07/11/24			completed and documented a		
	_				part of the facility's Preventive	,	
		and 12:15 p.m. during a tour of Maintenance Director, there			Maintenance Program and	oulto.	
	-	lectrical receptacles in each			document those inspection reason as appropriate. If any issues		
	resident room.	rectrical receptacies in each			discovered, they will be addre		
	resident room.				and resolved immediately. Th		
	This finding was re	viewed with the Director of			Maintenance Supervisor/design		
	_	enance Director during the exit			will review with the Administra		
	conference on 07/1	_			the inspection results.	itoi	
	conference on 07/1	1/27.			c The Administrator will		
	3.1-19(b)				monitor adherence to the		
	3.1-17(0)				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 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		
					the QA/PI Committee with	-	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained		

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	05	COMPL	ETED
		155770	B. W	NG		07/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				STER BARBARA WAY		
WATERS	OF GEORGETOW	/N, THE	_	GEORG	GETOWN, IN 47122		
(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			DATE
					This plan of correction constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is		
					8/16/2024.		
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 05	· ·	s - Essential Electric					
	System Maintenar						
	_	other alternate power					
		ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	_	nis capability for the life					
	-	branches. Maintenance generator and transfer					
	_	rmed in accordance with					
	NFPA 110.	inica in accordance with					
		e inspected weekly,					
		pad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
		nths for 4 continuous hours.					
	Scheduled test un	der load conditions include					
	a complete simula	ted cold start and					
	automatic or manu	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	• • • • • • • • • • • • • • • • • • • •	rces (Type 3 EES) are in					
		IFPA 111. Main and feeder					
		e inspected annually, and a					
		lically exercising the					
	-	ablished according to irements. Written records					
	•	nd testing are maintained					
		ble. EES electrical panels					
	-	arked, readily identifiable,					
		normal power circuits.					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 75 of 135

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>05</u>	(X3) date survey completed 07/11/2024	
	PROVIDER OR SUPPLIE S OF GEORGETOV		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	emergency powe consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1 Based on record refailed to maintain a monthly generator during 1 of the pass 6.4.4.1.1.4(a) of 20 testing of the generelectrical system to 110, the Standard frowers Systems, CNFPA 99 requires performance, exercing generator to be regional for inspection by the jurisdiction. Chapter requires batteries for maintained in accompliance with meaning the compliance with meaning the systems. Some systems are compliance with meaning period, a maintained and available to the systems. The systems are considered weekly a compliance with meaning period, a maintained and available to the systems. Some systems are considered weekly a compliance with meaning period, a maintained and available to the systems. Findings include:	NFPA 99), NFPA 110, 0 (NFPA 70) view and interview, the facility a complete written record of load testing for 1 of 1 generator t 12 months. Chapter 112 NFPA 99 requires monthly rator serving the emergency be in accordance with NFPA for Emergency and Standby Chapter 8. Chapter 6.4.4.2 of a written record of inspection, rising period, and repairs for the ularly maintained and available	K 0918	K918 – Building 08 - It is the intent of the facility to ensure the maintain a complete written resoft monthly generator load test for generator during the past twelve months to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 7/15/2024 the Maintenance Supervisor conducted the monthly load testing for the emergency generator and documented the results in the facilities Life Safi Binder to meet set standards. The Administrator verified the on 7/15/2024. 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 PREVE REOCCURRENCE: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement to conduct testing on the emergency generator including the month testing to meet set standards. b The Maintenance Supervisor/designee will ensu conduct all testing on the	ecord ing Be ety work ED: f to NT gnee all	

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>05</u>	COMPLETED
		155770	B. W	ING		07/11/2024
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DLAN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		7/10/24 between 10:15 a.m. and			emergency generator includin	~ I
	_	Maintenance Director present,			monthly load testing as a part	of
		ly generator load test			the facility's Preventive	
		lable for June of 2024 for the			Maintenance Program and	
		or. Based on interview at the			document those inspection re-	
		w, the Maintenance Director			as appropriate. If any issues	
	-	been in a transition period and the monthly load test of			discovered, they will be addre	
	_	erator was not completed.			and resolved immediately. The Maintenance Supervisor/design	
	the emergency gene	trator was not completed.			will review with the Administra	
	This finding was re	viewed with the Director of			the inspection results.	illoi
	_	enance Director during the exit			c The Administrator will	
	conference on 07/1	_			monitor adherence to the	
					Preventative Maintenance	
	3.1-19(b)				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	nce
					Supervisor/designee to the	
					Administrator monthly and the	:
					Administrator will present the	
					inspection results at the montl	•
					Quality Assurance/Performan	
					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	15
					compliance is maintained.	
					This plan of correction	
					constitutes our credible	
					allegation of compliance with	h
					all regulatory requirements.	
					Our date of compliance is	
					8/16/2024	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 155770 B. WING 07/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN. IN 47122 (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) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0000 Bldg. 06 A Life Safety Code Recertification and State K 0000 Preparation and/or execution Licensure Survey was conducted by the Indiana of this plan of correction in Department of Health in accordance with 42 CFR general, or this corrective 483.90(a). action in particular does not constitute and admission or Survey Dates: 07/10/24 and 07/11/24 agreement by this facility of the facts alleged, or conclusions Facility Number: 011509 set forth in this statement of Provider Number: 155770 deficiencies. The plan of AIM Number: 200909280 correction and specific corrective actions are prepared At this Life Safety Code survey, The Waters of and/or executed in compliance Georgetown, was found not in compliance with with state and federal laws. Requirements for Participation in This plan of correction Medicare/Medicaid, 42 CFR Subpart 483.90(a), constitutes our credible Life Safety from Fire and the 2012 edition of the allegation of compliance with National Fire Protection Association (NFPA) 101, all regulatory requirements. Life Safety Code (LSC), and 410 IAC 16.2. Villa Our date of compliance is 1006 was surveyed with Chapter 19, Existing August 16, 2024. This provider Health Care Occupancies. respectfully requests that this 2567 Plan of Correction be This one story facility was determined to be of considered the Letter of Type V (111) construction and fully sprinkled. Credible Allegation of The facility has a fire alarm system with smoke Compliance and requests a detection in the corridors, spaces open to the desk review in lieu of a post corridors, and all resident sleeping rooms. The survey revisit. facility has a capacity of 10 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 07/16/24

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 78 of 135

, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	06	COMPL	ETED
		155770	B. W	ING	_	07/11/	2024
	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122		•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		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 OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 06	Maintenance						
	Fire Alarm System	ո - Testing and					
	Maintenance						
	A fire alarm syster	m is tested and maintained					
	in accordance with	n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
	National Fire Alarr	m and Signaling Code.					
	Records of system acceptance, maintenance						
	and testing are readily available.						
	9.6.1.3, 9.6.1.5, N	FPA 70, NFPA 72					
	1. Based on record	review and interview, the	K 0	345	K345 – Building 8 - It is the		08/16/2024
	facility failed to ens	sure the annual testing of all			intent of the facility to ensure	the	
	devices connected to	o 1 of 1 fire alarm system was			annual testing of all devices		
	performed. NFPA	72, National Fire Alarm Code,			connected to fire alarm syster	ns	
	the 2010 Edition, at	14.6.2.4 requires a record of all			are performed and to maintain	n fire	
	inspections, testing,	, and maintenance shall be			alarm system in accordance v	vith	
	provided that includ	les the following information			NFPA 72, as required by LSC	101	
	regarding tests and	all the applicable information			Sections 19.3.4.5.1 and 9.6 a	nd to	
	requested in Figure	14.6.2.4:			ensure complete documentati	on is	
	(1) Date				available for the sensitivity tes	sting	
	(2) Test frequency				of all hard wired smoke detect	tors	
	(3) Name of propert	ty			and to show what testing		
	(4) Address				instrument is used to test all		
	(5) Name of person	performing inspection,			smoke detectors for sensitivity	/ to	
	maintenance, tests,	or combination thereof, and			meet set standards.		
	affiliation, business	address, and telephone			1 CORRECTIVE ACTIONS	S	
	number				TAKEN:		
	(6) Name, address,	and representative of			a On 8/9/2024 the facilities	S	
	approving agency (i				licensed contractor performed	the	
		he detector(s) tested			annual fire alarm system		
	(8) Functional test of				inspection / test report and		
	(9)*Functional test	of required sequence of			documented in the facilities Li	fe	
	operations				Safety Binder to meet set		
	(10) Check of all sn				standards. The Administrator		
	(11) Loop resistance	e for all fixed-temperature,			verified the work on 8/9/2024.		
	line-type heat detect				b On 8/9/2024 the facilities		
	(12) Functional test of mass notification system				licensed contractor performed	the	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	06	COMPLE	TED
		155770	B. W	ING		07/11/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEI	8			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE			GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	control units				semi-annual visual fire alarm		
	(13) Functional test of signal transmission to mass				system inspection and		
	notification systems				documented in the facilities Li	ife	
	(14) Functional test of ability of mass notification				Safety Binder to meet set		
	system to silence fire alarm notification appliances				standards. The Administrator	I .	
	(15) Tests of intelligibility of mass notification				verified the work on 8/9/2024.		
	system speakers				c On 8/9/2024 the facilitie	I	
	1 1	required by the equipment			license contractor performed	I .	
	manufacturer's pub				biannual sensitivity testing on	the	
	1 1	required by the authority			fire alarm system smoke		
	having jurisdiction				detectors and documented th		
		ester and approved authority			results in the Life Safety Bind	er	
	representative				and also documented the		
		problems identified during test			manufacturer's calibrated		
	(e.g., system owner	-			sensitivity test instrument fron	n the	
	corrected/successfu	-			fire alarm system inspection		
	abandoned in place				contractor to meet set standa		
	_	ice could affect all occupants			The Administrator verified the	work	
	in the facility.				on 8/9/2024.		
					2 ALL OTHERS WITH		
	Findings include:				POTENTIAL TO BE AFFECT		
					a All residents and all staf		
		view on 07/10/24 between 10:15			and visitors have the potentia	l to	
	-	with the Maintenance Director			be affected but none were.		
		was unable to provide an			3 MEASURES TO PREVE	NT	
		ystem inspection/test report			REOCCURRENCE:		
	1 .	ne past 12 month period. The			a On 8/6/2024 the		
	most recent annual	•			Administrator in serviced the		
		ort was dated 06/15/23			Maintenance Supervisor/design	-	
	1 -	acility's fire alarm system			on the requirement to ensure		
		nterview at the time of record			alarm systems are maintained	I .	
		nfirmed by the Maintenance			properly including the semi-ar	nnual	
	Director.				and annual fire alarm system		
	This finding	viawad with the Ditf			inspections and testing		
	_	viewed with the Director of			documents to be retained in the	I	
		enance Director during the exit			facilities Life Safety Binder an	a to	
	conference on 07/1	1/24.			ensure the smoke detector	_	
	2.1.10(1)				sensitivity test of all hard wire		
	3.1-19(b)				smoke detectors contains the		
					name of the manufacturer's		

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	06	COMPL	ETED
		155770	B. W	ING		07/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			STER BARBARA WAY		
\\/\TED	C OF GEODGETON	VN THE			GETOWN, IN 47122		
WATERS	OF GEORGETOV	VIN, I TIE		GEORG	3ETOWN, IN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		review and interview, the			calibrated sensitivity test		
	facility failed to maintain 1 of 1 fire alarm system in				instrument to meet set standa	rds.	
	accordance with NFPA 72, as required by LSC 101				b Maintenance		
	Sections 19.3.4.5.1 and 9.6. NFPA 72, Section				Supervisor/designee will ensu	re	
	14.3.1 states that un	nless otherwise permitted by			fire alarm systems are maintai	ined	
	_	ctions shall be performed in			properly including the semi-an	ınual	
	accordance with the	e schedules in Table 14.3.1, or			and annual fire alarm system		
	-	red by the authority having			inspections and testing		
	-	14.3.1 states that the following			documents to be retained in th	ne	
		spected semi-annually:			facilities Life Safety Binder and	d to	
	a. Control unit troul	ble signals			ensure the smoke detector		
	b. Remote annuncia	ntors			sensitivity test of all hard wired	b	
	 c. Initiating devices 	(e.g. duct detectors, manual			smoke detectors contains the		
	fire alarm boxes, he	eat detectors, smoke detectors,			name of the manufacturer's		
	etc.)				calibrated sensitivity test		
	d. Notification appl	iances			instrument as a part of the		
	e. Magnetic hold-op	pen devices			facility's Preventive Maintenar	nce	
	This deficient pract	ice could affect all residents,			Program and document those		
	staff, and visitors in	the facility.			inspection results as appropria	ate.	
					If any issues are discovered, t	hey	
	Findings include:				will be addressed and resolve	d	
					immediately. The Maintenanc	е	
	Based on record rev	view on 07/10/24 between 10:15			Supervisor/designee will revie	W	
	a.m. and 4:30 p.m.	with the Maintenance Director			with the Administrator the		
	-	no documentation provided			inspection results.		
		nnual visual fire alarm system			c The Administrator will		
		ne past 12 month period. The			monitor adherence to the		
	only fire alarm syst	em inspection/test provided			Preventative Maintenance		
	was dated 06/15/23	for an annual fire alarm			schedule and validate the		
		ne facility's vendor. Based on			Preventative Maintenance		
	interview at the tim	e of record review, the			documentation is in place.		
		tor confirmed there was no			4 MONITORING		
		inspection of the facility's fire			CORRECTIVE ACTION:		
	alarm system device	es performed during the past			a The inspection results w	ill	
	12 month period.				be presented by the Maintena	nce	
					Supervisor/designee to the		
	This finding was re	viewed with the Director of			Administrator and the		
	Nursing and Mainte	enance Director during the exit			Administrator will present the		
	conference on 07/1	1/24.			inspection results at the month	าly	
			1		Quality Assurance/Performan	20	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		l í	JILDING	ONSTRUCTION <u>06</u>	(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF I	PROVIDER OR SUPPLIEI	R	•		ADDRESS, CITY, STATE, ZIP COD	
WATERS	S OF GEORGETOV	VN, THE			ISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	3.1-19(b)				Improvement (QA/PI) meeting	
					Inspection results and system	
	3. Based on record review and interview, the				components will be reviewed	by
	I	sure complete documentation			the QA/PI Committee with	
		ne sensitivity testing of all hard			subsequent plans of correctio	
		tors, and to show what testing			developed and implemented a	as
		d to test all smoke detectors			deemed necessary to ensure	
	1	PA 72, National Fire Alarm			compliance is maintained.	
		, Section 14.4.5.3.1 states			This plan of correction	
	<u> </u>	shall be checked within 1 year			constitutes our credible	
	· ·	every alternate year thereafter.			allegation of compliance wit	n
		quired calibration test, if			all regulatory requirements.	
		icate that the detector has			Our date of compliance is	
		listed and marked sensitivity			8/16/2024.	
		f time between calibration tests				
	_	to be extended to a maximum of				
		uency is extended, records of				
		sance alarms and subsequent ms shall be maintained. In				
		re nuisance alarms show an				
		revious year, calibration tests				
	_	To ensure that each smoke				
	_	s listed and marked sensitivity				
		sted using any of the methods:				
	(1) Calibrated test i					
	1 1	calibrated sensitivity test				
	instrument.	Tailot account they took				
		quipment arranged for the				
	purpose.	1 1				
		/fire alarm control unit				
	` '	by the detector causes a signal				
	_	where its sensitivity is outside				
	its listed sensitivity					
		l sensitivity method acceptable				
	to the authority hav					
	1	have sensitivity outside the				
		sensitivity range shall be				
	cleaned and recalib					
		ivity cannot be tested or				
		y spray device that administers				

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 82 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155770	r í	JILDING	06	COMPL 07/11/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	1002 SI	ODDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	an unmeasured cond detector. This defice residents, staff, and Findings include: Based on record revelous. Based on recor	entration of aerosol into the ient practice could affect all visitors in the facility. iew on 07/10/24 between 10:15 with the Maintenance Director ocumentation available to tor sensitivity test of all hard ors was performed on 06/15/23 alarm system inspection e report did not include the cturer's calibrated sensitivity s was confirmed by the or at the time of record review.		IAU			DATE
K 0353 SS=F Bldg. 06	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an						

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 83 of 135

08/02/2024 PRINTED: 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. BUILDING COMPLETED 06 B. WING 07/11/2024 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 WATERS OF GEORGETOWN, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the K 0353 K353 – Building 08 It is the intent 08/16/2024 facility failed to provide written documentation or of the facility to ensure to provide other evidence the sprinkler system components written documentation or other had been inspected and tested for 1 of 4 quarters evidence the sprinkler system for 1 of 1 sprinkler system. LSC 4.6.12.1 requires components have been inspected any device, equipment or system required for and tested for 1 of 4 quarters for compliance with this Code be maintained in the sprinkler system and to accordance with applicable NFPA requirements. ensure to document sprinkler Sprinkler systems shall be properly maintained in system inspections in accordance accordance with NFPA 25, Standard for the with NFPA 25 the dry sprinkler Inspection, Testing, and Maintenance of system's pressure gauges and Water-Based Fire Protection Systems. NFPA 25, during 10 of the past 12 months 4.3.1 requires records shall be made for all for the sprinkler system's control inspections, tests, and maintenance of the system valves to meet set standards. components and shall be made available to the **1.CORRECTIVE ACTIONS** authority having jurisdiction upon request. 4.3.2 TAKEN: requires that records shall indicate the procedure 1.On 8/9/2024 the facilities performed (e.g., inspection, test, or maintenance), licensed sprinkler contractor the organization that performed the work, the performed the quarterly sprinkler results, and the date. NFPA 25, 5.2.5 requires that inspection and documented the waterflow alarm devices shall be inspected results in the facilities Life Safety quarterly to verify they are free of physical Binder to meet set standards. damage. NFPA 25, 5.3.3.1 requires the mechanical The Administrator verified the work waterflow alarm devices including, but not limited on 8/9/2024. to, water motor gongs, shall be tested quarterly. 2.On 7/31/2024 the 5.3.3.2 requires vane-type and pressure Maintenance Supervisor performed switch-type waterflow alarm devices shall be the weekly inspection of the tested semiannually. This deficient practice could facilities dry sprinkler system affect all residents, staff, and visitors in the gauges and documented the facility. results in the facility life safety binder to meet set standards. The Findings include: Administrator verified the work on 7/31/2024 Based on review of the quarterly sprinkler system 3.On 7/31/2024 the inspection records on 07/10/24 between 10:15 a.m. Maintenance Supervisor performed and 4:30 p.m. with the Maintenance Director the monthly inspection of the

OZM221

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 06 155770 B. WING 07/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (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 present, there was no quarterly sprinkler system facilities sprinkler system control inspection report available for the second quarter valves and documented the results (April, May, and June) of 2024. Based on in the facility life safety binder to interview at the time of record review, the meet set standards. The Maintenance Director confirmed there was no Administrator verified the work on written documentation available to show the 7/31/2024. sprinkler system had been inspected during the 2.ALL OTHERS WITH second quarter of 2024. POTENTIAL TO BE AFFECTED: 1.All residents and all staff This finding was reviewed with the Director of and visitors have the potential to Nursing and Maintenance Director during the exit be affected but none were. conference on 07/11/24. **3.MEASURES TO PREVENT** REOCCURRENCE: 3.1-19(b)1.On 8/6/2024 the Administrator in serviced the 2. Based on record review, observation, and Maintenance Supervisor/designee interview; the facility failed to document sprinkler on the requirement to ensure sprinkler inspections are system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 47 of the conducted and documented past 52 weeks for the sprinkler system's pressure including the quarterly sprinkler gauges, and during 10 of the past 12 months for inspection, weekly inspection of the sprinkler system's control valves. NFPA 25, the gauges and the monthly Standard for the Inspection, Testing, and inspection of the control valves to Maintenance of Water-Based Fire Protection meet set standards. Systems, 2011 Edition, Section 5.2.4.2 states 2.Maintenance gauges on dry pipe sprinkler systems shall be Supervisor/designee will ensure inspected weekly to ensure that normal air and sprinkler inspections are water pressures are being maintained. Section conducted and documented 5.1.2 states valves and fire department including the quarterly sprinkler connections shall be inspected, tested, and inspection, weekly inspection of maintained in accordance with Chapter 13. the gauges and the monthly Section 13.1.1.2 states Table 13.1.1.2 shall be inspection of the control valves as utilized for inspection, testing and maintenance of a part of the facility's Preventive valves, valve components and trim. Section 4.3.1 Maintenance Program and states records shall be made for all inspections, document those inspection results tests, and maintenance of the system and its as appropriate. If any issues are components and shall be made available to the discovered, they will be addressed authority having jurisdiction upon request. This and resolved immediately. The deficient practice could affect all residents, staff, Maintenance Supervisor/designee and visitors in the facility. will review with the Administrator

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING (06) COMPLETI				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			06	COMPL	
		155770	B. W	ING		07/11/	2024
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	REGULATORY OR Findings include: a. Based on record 10:15 a.m. and 4:30 Director present, the available to show the system gauges were of the past 52 week sprinkler gauge insp. June and July of 20 time of record revier confirmed there was to show that the face been inspected at let past 52 weeks. Base 07/11/24 between 9 tour of the facility with the facility had two sprinkler riser. b. Based on record 10:15 a.m. and 4:30 Director present, the system control valve for 10 of the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems was record to the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems available and the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections during the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections available 2024. Based on interview, the Mainter lack of sprinkler systems during the past 12 inspections available 2024. Based on interview, the finding was reconstituted and the past 12 inspections available 2024. Based on interview, the finding was reconstituted and the past 2024 and 2024 an	review on 07/10/24 between 0 p.m. with the Maintenance ere was no documentation are facility's dry sprinkler erinspected weekly during 47 period. The only weekly bections were for the weeks in 24. Based on interview at the two, the Maintenance Director is no documentation available exility's sprinkler gauges have ast weekly during 47 of the ed on observations on exists a.m. and 12:15 p.m. during a with the Maintenance Director pressure gauges at the existence of the maintenance ere was no monthly sprinkler es inspection documentation of months. The only monthly erview at the time of record cance Director confirmed the stem inspections on the control			the inspection results. 3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECT ACTION: 1. The inspection results to be presented by the Maintenan Supervisor/designee to the Administrator monthly and 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 all regulatory requirements. Our date of compliance is 8/16/2024.	IVE will nce hly ce l. by	
K 0712	3.1-19(b) NFPA 101	1/24.					
SS=F	Fire Drills						

f .		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	06	COMPLETED	
		155770	B. W	ING		07/11/2024	1
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		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	CON	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 06	alarm signal and seconditions. Fire drand unexpected tile conditions, at leas The staff is familia aware that drills all routine. Where draware that drills all routine. The sased on record facility failed to produce the drills all residents, as well as facility. Findings include: Based on review of on 07/10/24 betwee the Maintenance Di only able to provide reports for the past following shifts and reports: a. The first shift (da August, and Septemb. The second shift (July, August, and Septemb. The shift (naugust, and Septembased on interview Based on interview	9.7.1.7 review and interview, the vide quarterly fire drill of 3 shifts during 3 of 4 ient practice could affect all staff and visitors in the the facility's fire drill reports in 10:15 a.m. and 4:30 p.m. with rector present, the facility was eight documented fire drill 12 month period. The quarters were missing fire drill any) of the third quarter (July, aber) of 2023. (evening) of the third quarter reports and December) of 2023, and y, February, and March) of ight) of the third quarter (July,	K 0	712	K712 – Building 08 - It is the intent of the facility to ensure the provide quarterly fire drill documentation for 3 shifts during all 4 quarters and to ensure fire drill reports included complete documentation of the transmiss of a fire alarm signal to the monitoring company/fire department during the past two months to meet set standards 1 CORRECTIVE ACTIONS TAKEN: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement that fire drimust be conducted at unexpectimes under varying conditions least quarterly on each shift and documented to meet set standards. b On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/design on the requirement to include documentation for the	ng e sion elve lis cted at at	/16/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 06 COMPLETED B. WING 07/11/2024			
	PROVIDER OR SUPPLIED S OF GEORGETOV		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	fire drill reports for	the previously mentioned		transmission of the alarm to the	ne
	shifts and quarters			monitoring company to meet s	set
				standards.	
	This finding was reviewed with the Director of			c On 8/6/2024 the	
	Nursing and Maintenance Director during the exit			Administrator in-serviced the	
	conference on 07/1	1/24.		Maintenance Supervisor/design	gnee
				on the requirement to ensure	fire
	3.1-19(b)			drills are held on varied dates	for
	3.1-51(c)			all shifts and quarters to meet	set
				standards.	
	2. Based on record review and interview, the			2 ALL OTHERS WITH	
	facility failed to ensure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECTI	ED:
	included complete documentation of the			a All residents and all staf	f
	transmission of a fi	re alarm signal to the		and visitors have the potential	l to
	monitoring compar	ny/fire department during the		be affected but none were.	
	past twelve months	s. LSC 19.7.1.4 requires fire		3 MEASURES TO PREVE	ENT
	drills in health care	occupancies shall include the		REOCCURRENCE:	
	transmission of the	fire alarm signal and		a Maintenance	
	simulation of emer	gency conditions. This		Supervisor/designee will ensu	ıre
	deficient practice c	ould affect all residents.		fire drills are conducted at	
				unexpected times under varyi	ng
	Findings include:			conditions at least quarterly or	n
				each shift and that documenta	ation
		f the facility's fire drill reports		be retained in the facility's Life	e
	on 07/10/24 betwee	en 10:15 a.m. and 4:30 p.m. with		Safety Binder and all reports v	will
		irector present, 3 of 8 fire drill		have documentation for the	
	reports performed of	during the past 12 month period		transmission of the alarm to the	ne
	were not provided	with documentation for the		monitoring company and will	
	transmission of the	alarm to the monitoring		ensure fire drills are held on v	aried
		rill dates and times include:		dates for all shifts and quarter	rs as
		m., 02/27/24 at 9:45 p.m., 05/28/24		a part of the facility's Preventi	ve
	^	ed on interview at the time of		Maintenance Program and	
		Maintenance Director		document those inspection re-	sults
	_	e was no information on 3 of 8		as appropriate. If any issues	are
	_	verify that transmission of the		discovered, they will be addre	ssed
	alarm was received	by the monitoring company.		and resolved immediately. Th	ne
				Maintenance Supervisor/design	gnee
	This finding was re	eviewed with the Director of		will review with the Administra	-
	Nursing and Maint	enance Director during the exit		the inspection results.	

conference on 07/11/24.

The Administrator will

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	06	COMPLETED	
		155770	B. WI	NG		07/11/2024	
				CEREE	ADDRESS CHILL CHARLE THE COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\ \A\ATED	0.0000000000000000000000000000000000000	A/N. T.I.E			ISTER BARBARA WAY		
WATERS	S OF GEORGETON	WN, THE		GEOR	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN		(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	COMPLET	ION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
					Preventative Maintenance		
	3. Based on record	I review and interview, the			documentation is in place.		
		sure fire drills were held on			4 MONITORING		
		shifts and quarters. This			CORRECTIVE ACTION:		
		ould affect all residents in the			a The inspection results w	iii l	
	facility.	outa urreet urr residents in the			be presented by the Maintena		
	lucinty.				Supervisor/designee to the		
	Findings include:				Administrator monthly and the		
	i manigs metade.				Administrator will present the		
	D1				inspection results at the month	alv.	
Based on review of the facility's fire drill reports on 07/10/24 between 10:15 a.m. and 4:30 p.m. with				1 .	•		
		irector present, there were			Quality Assurance/Performan		
					Improvement (QA/PI) meeting	•	
		fire drills performed during the od and on three occasions			Inspection results and system		
		drills performed on the same			components will be reviewed	oy	
		27/24, and 05/28/24). Based on			the QA/PI Committee with	_	
		ne of record review, the			subsequent plans of correction		
					developed and implemented a	is	
		tor acknowledged there were			deemed necessary to ensure		
		s documented during the past			compliance is maintained.		
	_	nd there were three occasions			This plan of correction		
		ls were performed during the			constitutes our credible		
	same day.				allegation of compliance with	า	
	TEL : (* 1:				all regulatory requirements.		
	_	eviewed with the Director of			Our date of compliance is		
		enance Director during the exit			8/16/2024.		
	conference on 07/1	1/24.					
					K914 – Building 01 - It is the		
	3.1-19(b)				intent of the facility to ensure		
	3.1-51(c)				complete documentation is		
					available for all non hospital of	ırade	
					electrical receptacles in all		
					resident room locations are te	sted	
					at least annually to meet set		
					standards.		
					1 CORRECTIVE ACTIONS	6	
					TAKEN:		
1					a On 8/7/2024 the		

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>06</u>	(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
	OF GEORGETOW			SISTER BARBARA WAY		
WAIERS	OF GEORGEION	VIN, 117E	GEOF	RGETOWN, IN 47122		
(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 APPROPRI DEFICIENCY)		
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	Maintenance Supervisor/desi	DATE	
				conducted the annual electric	~	
				receptacle inspection and	July 1	
				documented the results in the	e	
				facilities Life safety binder to		
				set standards. The Administr	I	
				verified repairs on 8/7/2024.		
				2 ALL OTHERS WITH		
				POTENTAL TO BE AFFECT		
				a All residents and all sta		
				and visitors have the potentia	il to	
				be affected but none were.	-NT	
				3 MEASURES TO PREVI	ENI	
				a On 8/6/2024 the		
				Administrator in-serviced the		
				Maintenance Supervisor/desi	anee	
				on the requirement the annua	-	
				electrical receptacle inspection	I	
				and testing must be complete	I	
				annually and documented in	I	
				life safety binder to meet set		
				standards.		
				b Maintenance		
				Supervisor/designee will ens		
				the annual electrical receptad	cle	
				inspection and testing is		
				completed and documented a		
				part of the facility's Preventive Maintenance Program and	-	
				document those inspection re	eulte	
				as appropriate. If any issues	I	
				discovered, they will be addre	I	
				and resolved immediately. T	I	
				Maintenance Supervisor/desi		
				will review with the Administra	~	
				the inspection results.		
				c The Administrator will		
				monitor adherence to the		
				Preventative Maintenance		

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet

Page 90 of 135

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 06 COMPLETED B. WING 07/11/2024			
	PROVIDER OR SUPPLIEF		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY	A LSC IDENTIFYING INFORMATION		schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results we be presented by the Maintenance Supervisor/designee to the Administrator and the Administrator will present the inspection results at the monting Quality Assurance/Performan 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 all regulatory requirements. Our date of compliance is 8/16/2024.	hlly ce J. by	
K 0914 SS=F Bldg. 06	Testing Electrical Systems Testing Hospital-grade rec locations and whe anesthesia is adm initial installation, Additional testing	s - Maintenance and s - Maintenance and ceptacles at patient bed are deep sedation or general ainistered, are tested after areplacement or servicing. ais performed at intervals ented performance data.				

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

Receptacles not listed as hospital-grade at

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 91 of 135

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	06	COMPI	LETED
		155770	B. W	ING		07/11	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATER!	S OF GEORGETOV	NN THE			GETOWN, IN 47122		
VV/ () L ()	- GEORGETOV	VIV, 111E		OLOIK	JETOWN, IN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
		re tested at intervals not					
	_	nths. Line isolation monitors					
	(LIM), if installed, are tested at intervals of						
	less than or equal to 1 month by actuating						
	the LIM test switch per 6.3.2.6.3.6, which						
		ual and audible alarm. For					
		automated self-testing, this					
	The state of the s	rformed at intervals less					
		2 months. LIM circuits are					
	tested per 6.3.3.3.2 after any repair or						
	renovation to the electric distribution system.						
	Records are maintained of required tests and						
	associated repairs or modifications,						
	containing date, room or area tested, and						
	results.						
	6.3.4 (NFPA 99)	on, record review and	IZ O	014	VO44 Building 00 It is the		09/17/2024
		ity failed to ensure complete	K 0	914	K914 – Building 08 - It is the		08/16/2024
	documentation was	-		intent of the facility to ensure complete documentation is			
		electrical receptacles in all			available for all non hospital g	arado	
		tions tested at least annually.			electrical receptacles in all	Jiaue	
		Care Facilities Code 2012 Edition,			resident room locations are te	etad	
		rates receptacles not listed as			at least annually to meet set	Sicu	
		patient bed locations and in			standards.		
		ep sedation or general			1 CORRECTIVE ACTIONS	3	
		nistered, shall be tested at			TAKEN:		
		ding 12 months. Additionally,			a On 8/7/2024 the		
		ceptacle Testing in Patient Care			Maintenance Supervisor/design	nee	
		e physical integrity of each			conducted the annual electrical	•	
	_	confirmed by visual inspection.			receptacle inspection and		
	The continuity of the	he grounding circuit in each			documented the results in the		
		e shall be verified. Correct			facilities Life safety binder to r	neet	
	polarity of the hot a	and neutral connections in			set standards. The Administra		
	each electrical rece	ptacle shall be confirmed; and			verified repairs on 8/7/2024.		
	retention force of the	he grounding blade of each			2 ALL OTHERS WITH		
	electrical receptacl	e (except locking-type			POTENTAL TO BE AFFECTE	D:	
		e not less than 115 grams (4			a All residents and all staf	f	
	ounces). This defic	ient practice could affect all			and visitors have the potential	to	
	residents.				be affected but none were.		
					3 MEASURES TO PREVE	.NT	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024		
	PROVIDER OR SUPPLIER		1	1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	(X5) COMPLETION
TAG	REGULATORY OF Findings include:	LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	rindings include.				REOCCURRENCE: a On 8/6/2024 the		
		view on 07/10/24 between 10:15			Administrator in-serviced the		
	a.m. and 4:30 p.m. with the Maintenance Director present, there was no documentation available of				Maintenance Supervisor/design		
	-				on the requirement the annua		
		oom receptacle test for non			electrical receptacle inspectio		
		otacles. Based on interview at eview, the Maintenance			and testing must be complete		
		the electrical receptacles in			annually and documented in t	ne	
		-			life safety binder to meet set standards.		
	resident rooms were not hospital-grade receptacles as far as he knew. He further said he				b Maintenance		
	could not find documentation to show that annual				Supervisor/designee will ensu	ırα	
	testing per NFPA 99, Receptacle Testing				the annual electrical receptac		
	requirements was met with all pertinent				inspection and testing is		
	*	the past 12 month period or			completed and documented a	s a	
		servations on 07/11/24			part of the facility's Preventive		
	-	and 12:15 p.m. during a tour of			Maintenance Program and	•	
		Maintenance Director, there			document those inspection re	sults	
	-	ectrical receptacles in each			as appropriate. If any issues		
	resident room.				discovered, they will be addre		
	100100111111111111111111111111111111111				and resolved immediately. Th		
	This finding was re	viewed with the Director of			Maintenance Supervisor/design		
		enance Director during the exit			will review with the Administra		
	conference on 07/1				the inspection results.		
					c The Administrator will		
	3.1-19(b)				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	rill	
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator and the		
					Administrator will present the		
					inspection results at the month	hly	
					Quality Assurance/Performan	ce	
					Improvement (QA/PI) meeting	l.	

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	ľ í	JILDING	nstruction <u>06</u>	(X3) DATE : COMPL 07/11/	ETED
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(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)	ΓE	(X5) COMPLETION DATE
K 0918	NEDA 101				Inspection 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. Our date of compliance is 8/16/2024.	n s	
SS=F Bldg. 06	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under for year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer frimed in accordance with le inspected weekly, lead 30 minutes 12 times a lintervals, and exercised hiths for 4 continuous hours. locetime definition of the capability of the life branches. Maintenance generator and transfer locetime definition of the capability of the life branches. Maintenance generator and transfer locetime definition of the capability of the locetime definition of the capability of the locetime definition of the capability of the locetime definition of the locetime de					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 94 of 135

08/02/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 06 B. WING 07/11/2024 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 WATERS OF GEORGETOWN, THE (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 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility K 0918 K918 - Building 08 - It is the 08/16/2024 failed to maintain a complete written record of intent of the facility to ensure to monthly generator load testing for 1 of 1 generator maintain a complete written record during 1 of the past 12 months. Chapter of monthly generator load testing 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly for generator during the past testing of the generator serving the emergency twelve months to meet set electrical system to be in accordance with NFPA standards. 110, the Standard for Emergency and Standby **CORRECTIVE ACTIONS** Powers Systems, Chapter 8. Chapter 6.4.4.2 of TAKEN: NFPA 99 requires a written record of inspection, On 7/15/2024 the performance, exercising period, and repairs for the Maintenance Supervisor generator to be regularly maintained and available conducted the monthly load for inspection by the authority having testing for the emergency jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 generator and documented the requires batteries for on-site generators shall be results in the facilities Life Safety maintained in accordance with NFPA 110, 2010 Binder to meet set standards. Edition, Standard for Emergency and Standby The Administrator verified the work Power Systems. 8.3.7 requires storage batteries, on 7/15/2024. including electrolyte levels or battery voltage, **ALL OTHERS WITH** POTENTIAL TO BE AFFECTED: used in connection with systems shall be inspected weekly and maintained in full All residents and all staff compliance with manufacturer's specifications. and visitors have the potential to 8.3.7.2 states defective batteries shall be repaired be affected but none were.

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

or replaced immediately upon discovery of

written record of inspection, performance,

defects. Chapter 6.5.4.2 of NFPA 99 requires a

exercising period, and repairs shall be regularly

maintained and available for inspection by the

Event ID:

OZM221

Facility ID: 011509

REOCCURRENCE:

On 8/6/2024 the

Administrator in-serviced the

Maintenance Supervisor/designee

If continuation sheet

MEASURES TO PREVENT

Page 95 of 135

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	06	COMPL	ETED
		155770	B. W	ING	_	07/11/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	authority having jur	risdiction. This deficient			on the requirement to conduct	all	
		et all residents, staff and			testing on the emergency		
	visitors.				generator including the month	lv	
					testing to meet set standards.	,	
	Findings include:				b The Maintenance		
					Supervisor/designee will ensu	re to	
	Based on review of	the generator inspection and			conduct all testing on the		
		7/10/24 between 10:15 a.m. and			emergency generator including	g the	
		Maintenance Director present,			monthly load testing as a part	-	
	there was no monthly generator load test				the facility's Preventive		
	documentation available for June of 2024 for the				Maintenance Program and		
	emergency generator. Based on interview at the				document those inspection res	sults	
	time of record review, the Maintenance Director				as appropriate. If any issues		
	said the facility has been in a transition period				discovered, they will be address		
	with new ownership and the monthly load test of				and resolved immediately. Th		
		erator was not completed.			Maintenance Supervisor/desig		
		•			will review with the Administra		
	This finding was re	viewed with the Director of			the inspection results.		
	_	enance Director during the exit			c The Administrator will		
	conference on 07/1	_			monitor adherence to the		
					Preventative Maintenance		
	3.1-19(b)				schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w	ill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performand	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed to	ру	
					the QA/PI Committee with		
					subsequent plans of correction	า	
					developed and implemented a		
					deemed necessary to ensure		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	06	COMPL	ETED
		155770	B. W	ING		07/11/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
					compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/16/2024.	1	
K 0000							
Bldg. 07							
Bidg. 07	Licensure Survey we Department of Hea 483.90(a). Survey Date: 07/10 Facility Number: 0 Provider Number: 200 At this Life Safety Georgetown, was for Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I 1007 was surveyed Health Care Occup This one story facil Type V (111) const The facility has a fi detection in the cor corridors, and all recompositions.	201509 155770 155770 1909280 Code survey, The Waters of bund not in compliance with articipation in 1, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ection Association (NFPA) 101, LSC), and 410 IAC 16.2. Villa with Chapter 19, Existing ancies. Ity was determined to be of ruction and fully sprinkled. The alarm system with smoke ridors, spaces open to the sident sleeping rooms. The ity of 10 and had a census of 6	K 0	000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepar and/or executed in compliant with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 16, 2024. This provious respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.	the red ce	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 97 of 135

PRINTED: 08/02/2024 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 07/11/2024			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
K 0345 SS=F Bldg. 07	were sprinkled and services with a special services of system and testing are respected performed. NFPA the 2010 Edition, a inspections, testing provided that inclure garding tests and requested in Figure (1) Date (2) Test frequency (3) Name of persormaintenance, tests,	mpleted on 07/16/24 m - Testing and m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance adily available. IFPA 70, NFPA 72 I review and interview, the sure the annual testing of all to 1 of 1 fire alarm system was 72, National Fire Alarm Code, t 14.6.2.4 requires a record of all , and maintenance shall be des the following information all the applicable information e 14.6.2.4:	K 0345	K345 – Building 8 - It is the intent of the facility to ensure the annual testing of all devices connected to fire alarm system are performed and to maintain alarm system in accordance with NFPA 72, as required by LSC Sections 19.3.4.5.1 and 9.6 and ensure complete documentation available for the sensitivity test of all hard wired smoke detection and to show what testing instrument is used to test all smoke detectors for sensitivity meet set standards. 1 CORRECTIVE ACTIONS TAKEN:	fire fire ith 101 d to on is ing ors			

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

(6) Name, address, and representative of

(7) Designation of the detector(s) tested

approving agency (ies)

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

On 8/9/2024 the facilities

licensed contractor performed the

annual fire alarm system

Page 98 of 135

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	07	COMPLETED
		155770	B. Wl	ING		07/11/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	8			ISTER BARBARA WAY	
WATERS	S OF GEORGETOV	VN, THE			GETOWN, IN 47122	
	ı		1		, . <u></u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	(8) Functional test of				inspection / test report and	,
	(9)*Functional test of required sequence of				documented in the facilities Li	fe
	operations				Safety Binder to meet set	
	(10) Check of all smoke detectors				standards. The Administrator	
	(11) Loop resistance for all fixed-temperature,				verified the work on 8/9/2024.	
	line-type heat detectors				b On 8/9/2024 the facilities	
		of mass notification system			licensed contractor performed	tne
	control units (13) Eurotional test of signal transmission to mass				semi-annual visual fire alarm	
	(13) Functional test of signal transmission to mass				system inspection and	,
	notification systems				documented in the facilities Li	te
	(14) Functional test of ability of mass notification				Safety Binder to meet set	
	system to silence fire alarm notification appliances				standards. The Administrator	
	(15) Tests of intelligibility of mass notification				verified the work on 8/9/2024.	
	system speakers				c On 8/9/2024 the facilities	
	1 1	required by the equipment			license contractor performed t	
	manufacturer's publ				biannual sensitivity testing on	the
	1 1	required by the authority			fire alarm system smoke	
	having jurisdiction				detectors and documented the	
		ester and approved authority			results in the Life Safety Binde	er
	representative				and also documented the	
		problems identified during test			manufacturer's calibrated	
	(e.g., system owner				sensitivity test instrument fron	n the
	corrected/successfu	=			fire alarm system inspection	
	abandoned in place				contractor to meet set standar	
	_	ice could affect all occupants			The Administrator verified the	work
	in the facility.				on 8/9/2024.	
	E' 1' ' ' '				2 ALL OTHERS WITH	
	Findings include:				POTENTIAL TO BE AFFECTI	
		05/10/041			a All residents and all staf	
		view on 07/10/24 between 10:15			and visitors have the potential	to
	-	with the Maintenance Director			be affected but none were.	
		was unable to provide an			3 MEASURES TO PREVE	NT
		stem inspection/test report			REOCCURRENCE:	
		ne past 12 month period. The			a On 8/6/2024 the	
	most recent annual	_			Administrator in serviced the	
		rt was dated 06/14/23			Maintenance Supervisor/design	
		icility's fire alarm system			on the requirement to ensure	
		nterview at the time of record			alarm systems are maintained	
		nfirmed by the Maintenance			properly including the semi-ar	nual
	Director.				and annual fire alarm system	l

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	07	COMPL	ETED
		155770	B. W	ING		07/11	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ISTER BARBARA WAY		
\\/\TED	S OF GEORGETOV	VNI THE			GETOWN, IN 47122		
WATERS	OF GEORGETOV	VIN, I III		GEORG	3E 1 O WIN, IIN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					inspections and testing		
	_	viewed with the Director of			documents to be retained in the	ne	
	_	enance Director during the exit			facilities Life Safety Binder an	d to	
	conference on 07/1	1/24.			ensure the smoke detector		
					sensitivity test of all hard wire	d	
	3.1-19(b)				smoke detectors contains the		
					name of the manufacturer's		
		review and interview, the			calibrated sensitivity test		
	facility failed to maintain 1 of 1 fire alarm system in				instrument to meet set standa	rds.	
	accordance with NFPA 72, as required by LSC 101				b Maintenance		
	Sections 19.3.4.5.1	and 9.6. NFPA 72, Section			Supervisor/designee will ensu	ire	
	14.3.1 states that unless otherwise permitted by				fire alarm systems are mainta	ined	
	14.3.2, visual inspections shall be performed in				properly including the semi-ar	nual	
	accordance with the schedules in Table 14.3.1, or				and annual fire alarm system		
	more often if requir	red by the authority having			inspections and testing		
	jurisdiction. Table	14.3.1 states that the following			documents to be retained in the	ne	
	must be visually ins	spected semi-annually:			facilities Life Safety Binder an	d to	
	a. Control unit trou	ble signals			ensure the smoke detector		
	b. Remote annuncia	ators			sensitivity test of all hard wire	d	
	_	s (e.g. duct detectors, manual			smoke detectors contains the		
		eat detectors, smoke detectors,			name of the manufacturer's		
	etc.)				calibrated sensitivity test		
	d. Notification appl				instrument as a part of the		
	e. Magnetic hold-op	•			facility's Preventive Maintenar		
		ice could affect all residents,			Program and document those		
	staff, and visitors in	the facility.			inspection results as appropri		
					If any issues are discovered, t	they	
	Findings include:				will be addressed and resolve		
					immediately. The Maintenand		
		view on 07/10/24 between 10:15			Supervisor/designee will revie	•W	
	_	with the Maintenance Director	1		with the Administrator the		
		no documentation provided			inspection results.		
		nnual visual fire alarm system			c The Administrator will		
		ne past 12 month period. The			monitor adherence to the		
		em inspection/test provided			Preventative Maintenance		
		for an annual fire alarm			schedule and validate the		
		he facility's vendor. Based on			Preventative Maintenance		
		e of record review, the			documentation is in place.		
		tor confirmed there was no			4 MONITORING		
	semi-annual visual	inspection of the facility's fire			CORRECTIVE ACTION:		

PRINTED: 08/02/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEM	IENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	07	COMPLETED
		155770	B. WING		07/11/2024
	F PROVIDER OR SUPPLIER RS OF GEORGETOV SUMMARY		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
TAG	alarm system device 12 month period. This finding was re Nursing and Mainte conference on 07/1 3.1-19(b) 3. Based on record facility failed to ensure a was available for the wired smoke detect instrument was use for sensitivity. NFI Code, 2010 Edition detector sensitivity of installation, and After the second resensitivity tests independent of the second resensitivity tests in the second resensitivity tests in the frequency of the frequency o	review and interview, the sure complete documentation he sensitivity testing of all hard fors, and to show what testing d to test all smoke detectors PA 72, National Fire Alarm has section 14.4.5.3.1 states shall be checked within 1 year every alternate year thereafter. Quired calibration test, if iteate that the detector has histed and marked sensitivity fitime between calibration tests to be extended to a maximum of the uency is extended, records of sance alarms and subsequent the shall be maintained. In the renuisance alarms show an every reconstruction tests. To ensure that each smoke its listed and marked sensitivity sted using any of the methods:	TAG	a The inspection results w be presented by the Maintena Supervisor/designee to the Administrator 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 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 8/16/2024.	ill nce nly ce . by n ss
	at the control unit v	where its sensitivity is outside			

its listed sensitivity range.

		X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			A. BUILDING <u>07</u> B. WING			COMPLETED 07/11/2024		
		133770	B. W	_		07/11/	ZUZ 1		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD				
WATERS	OF GEORGETOW	VN, THE			STER BARBARA WAY GETOWN, IN 47122				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	to the authority hav	sensitivity method acceptable							
	_	have sensitivity outside the							
		ensitivity range shall be							
	cleaned and recalib	-							
	The detector sensiti	vity cannot be tested or							
		spray device that administers							
		centration of aerosol into the							
		vient practice could affect all visitors in the facility.							
	residents, starr, and	visitors in the facility.							
	Findings include:								
	Based on record rev	view on 07/10/24 between 10:15							
	_	with the Maintenance Director							
	1 ~	locumentation available to							
		etor sensitivity test of all hard							
		ors was performed on 06/14/23							
	1 -	alarm system inspection ne report did not include the							
		acturer's calibrated sensitivity							
		is was confirmed by the							
		for at the time of record review.							
	This finding was	viewed with the Director of							
	This finding was reviewed with the Director of Nursing and Maintenance Director during the exit								
	conference on 07/1	-							
	3.1-19(b)								
K 0353	NFPA 101								
SS=F	Sprinkler System	- Maintenance and Testing							
Bldg. 07	1 '	- Maintenance and Testing							
	I	er and standpipe systems							
	•	ted, and maintained in							
		NFPA 25, Standard for the							
		g, and Maintaining of							
		Protection Systems. n design, maintenance,							
	I -	sting are maintained in a							

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 102 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ЛLDING	07	COMPI	LETED
	155770		B. W	ING		07/11	/2024
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATERS	WATERS OF GEORGETOWN, THE			GEOR	GETOWN, IN 47122		<u> </u>
(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
		nd readily available.					
	a) Date sprinkle	r system last checked					
	b) Who provided system test						
	c) Water system	supply source					
		RKS information on					
		non-required or partial					
	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide written documentation or						
			17.0	2.52	KOSO Postletion of OO It in the sign	44	00/1/2024
			K 0353		K353 – Building 08 It is the intent of the facility to ensure to provide		08/16/2024
	other evidence the sprinkler system components				written documentation or othe		
		and tested for 1 of 4 quarters			evidence the sprinkler system		
	_	system. LSC 4.6.12.1 requires			components have been inspe		
	_	nent or system required for			and tested for 1 of 4 quarters		
		is Code be maintained in			the sprinkler system and to		
	accordance with ap	plicable NFPA requirements.			ensure to document sprinkler		
	Sprinkler systems s	shall be properly maintained in			system inspections in accorda		
	accordance with N	FPA 25, Standard for the			with NFPA 25 the dry sprinkle	r	
	Inspection, Testing	, and Maintenance of			system's pressure gauges an	d	
	Water-Based Fire I	Protection Systems. NFPA 25,			during 10 of the past 12 mont	hs	
	-	rds shall be made for all			for the sprinkler system's conf		
	_	and maintenance of the system			valves to meet set standards.		
	_	all be made available to the			1.CORRECTIVE ACTIONS		
		risdiction upon request. 4.3.2			TAKEN:		
	_	ls shall indicate the procedure			1.On 8/9/2024 the facilities	es	
		spection, test, or maintenance),			licensed sprinkler contractor		
	_	at performed the work, the			performed the quarterly sprink		
		e. NFPA 25, 5.2.5 requires that			inspection and documented the		
		evices shall be inspected			results in the facilities Life Saf	-	
		they are free of physical, 5.3.3.1 requires the mechanical			Binder to meet set standards.		
	_	evices including, but not limited			The Administrator verified the	WOIK	
		ngs, shall be tested quarterly.			on 8/9/2024. 2.On 7/31/2024 the		
		ne-type and pressure			Maintenance Supervisor perfo	armed	
		low alarm devices shall be			the weekly inspection of the	nilleu	
		y. This deficient practice could			facilities dry sprinkler system		
	1	staff and visitors in the			dauges and documented the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 07/11/2024			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION	
TAG	REGULATORY OF facility. Findings include: Based on review of inspection records of and 4:30 p.m. with present, there was reinspection report as (April, May, and Julinterview at the time Maintenance Direct written documentate sprinkler system has second quarter of 2. This finding was reen Nursing and Maintenance on 07/1. 3.1-19(b) 2. Based on record interview; the facility system inspections for 1 of 1 dry sprint past 52 weeks for the gauges, and during the sprinkler system Standard for the Instantance of Wasystems, 2011 Edit gauges on dry pipe inspected weekly to	The quarterly sprinkler system on 07/10/24 between 10:15 a.m. the Maintenance Director to quarterly sprinkler system vailable for the second quarter time) of 2024. Based on the of record review, the tor confirmed there was notion available to show the did been inspected during the 024. A reviewed with the Director of the time accordance with NFPA 25 kler system during 47 of the the sprinkler system's pressure 10 of the past 12 months for the sprinkler system's pressure 10 of the past 12 months for the sprinkler system, Testing, and the sprinkler system shall be to ensure that normal air and	TAG	results in the facility life safety binder to meet set standards. Administrator verified the wor 7/31/2024. 3.On 7/31/2024 the Maintenance Supervisor perfethe monthly inspection of the facilities sprinkler system convalves and documented the rin the facility life safety binder meet set standards. The Administrator verified the wor 7/31/2024. 2.ALL OTHERS WITH POTENTIAL TO BE AFFECT 1.All residents and all stand visitors have the potential be affected but none were. 3.MEASURES TO PREVEN REOCCURRENCE: 1.On 8/6/2024 the Administrator in serviced the Maintenance Supervisor/desion the requirement to ensure sprinkler inspections are conducted and documented including the quarterly sprinklinspection, weekly inspection the gauges and the monthly inspection of the control valvement set standards. 2.Maintenance Supervisor/designee will ensure sprinkler inspections are	y The ck on ormed ormed ormed ormed or the character of t	DATE	
	5.1.2 states valves a connections shall b maintained in according	being maintained. Section and fire department e inspected, tested, and rdance with Chapter 13.		conducted and documented including the quarterly sprinkl inspection, weekly inspection the gauges and the monthly inspection of the control valve.	of		

utilized for inspection, testing and maintenance of

a part of the facility's Preventive

PRINTED: 08/02/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	07	COMPLETED		
		155770	B. WI	NG		07/11/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	8			ISTER BARBARA WAY			
WATERS	OF GEORGETOV	VN, THE			GETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	valves, valve comp	onents and trim. Section 4.3.1			Maintenance Program and			
		be made for all inspections,			document those inspection re-	sults		
	tests, and maintenar	nce of the system and its			as appropriate. If any issues	are		
	components and sha	all be made available to the			discovered, they will be addre	ssed		
	authority having jurisdiction upon request. This deficient practice could affect all residents, staff,				and resolved immediately. Th	ie		
					Maintenance Supervisor/desig	gnee		
	and visitors in the fa	acility.			will review with the Administra	tor		
					the inspection results.			
	Findings include:				3.The Administrator will			
					monitor adherence to the			
	a. Based on record	review on 07/10/24 between			Preventative Maintenance			
	10:15 a.m. and 4:30	p.m. with the Maintenance			schedule and validate the			
	Director present, the	ere was no documentation			Preventative Maintenance			
	available to show th	ne facility's dry sprinkler			documentation is in place.			
	system gauges were	e inspected weekly during 47			4.MONITORING CORRECT	IVE		
	of the past 52 week	period. The only weekly			ACTION:			
	_	pections were for the weeks in			1.The inspection results v	will		
		24. Based on interview at the			be presented by the Maintena			
	I	ew, the Maintenance Director			Supervisor/designee to the			
		s no documentation available			Administrator monthly and the	!		
	to show that the fac	ility's sprinkler gauges have			Administrator will present the			
		ast weekly during 47 of the			inspection results at the month	nlv		
	_	ed on observations on			Quality Assurance/Performan	•		
	_	:45 a.m. and 12:15 p.m. during a			Improvement (QA/PI) meeting			
		with the Maintenance Director			Inspection results and system			
	· ·	pressure gauges at the			components will be reviewed l			
	sprinkler riser.				the QA/PI Committee with	,		
					subsequent plans of correction	n		
	b. Based on record review on 07/10/24 between				developed and implemented a			
	10:15 a.m. and 4:30	p.m. with the Maintenance			deemed necessary to ensure			
		ere was no monthly sprinkler			compliance is maintained.			
		es inspection documentation			This plan of correction			
	· ·	2 months. The only monthly			constitutes our credible			
	1	le were for June and July of			allegation of compliance with	h		
	_	erview at the time of record			all regulatory requirements.			
		nance Director confirmed the			Our date of compliance is			
	· ·	stem inspections on the control			8/16/2024.			
	valves during the pa	-						

This finding was reviewed with the Director of

ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION chance Director during the exit	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 07	3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and so conditions. Fire drills and unexpected to conditions, at least The staff is familia aware that drills a routine. Where drills a routine. Where drills a routine and incomplete alarms. 19.00 PM and 6:00 announcement mandible alarms. 19.7.1.4 through and through a large and the production of the past facility. Findings include: Based on review of on 07/10/24 between the Maintenance Drills and the provider reports for the past following shifts and reports: a. The first shift (drills August, and Septements)	the transmission of a fire simulation of emergency fire fills are held at expected mes under varying at quarterly on each shift. It with procedures and is repart of established fills are conducted between AM, a coded ay be used instead of 19.7.1.7 review and interview, the ovide quarterly fire drill as of 3 shifts during 3 of 4 cient practice could affect all as staff and visitors in the 10:15 a.m. and 4:30 p.m. with rector present, the facility was be eight documented fire drill 12 month period. The 13 quarters were missing fire drill any) of the third quarter (July,	K 0712	K712 – Building 08 - It is the intent of the facility to ensure to provide quarterly fire drill documentation for 3 shifts duri all 4 quarters and to ensure fire drill reports included complete documentation of the transmis of a fire alarm signal to the monitoring company/fire department during the past two months to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 8/6/2024 the Administrator in-serviced the Maintenance Supervisor/desig on the requirement that fire dri must be conducted at unexpectimes under varying conditions	ng e sion elve inee lls

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

(July, August, and September), and fourth quarter

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

least quarterly on each shift and

Page 106 of 135

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>07</u>			ETED
	155770		B. WING 07/11/2024			/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN. THE			GETOWN, IN 47122		
					1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
		er, and December) of 2023, and			documented to meet set		
		ry, February, and March) of			standards.		
	2024.	. 1. 2. 6.1. 4.1			b On 8/6/2024 the		
		night) of the third quarter (July,			Administrator in-serviced the		
	August, and Septen				Maintenance Supervisor/design	jnee	
		at the time of record review,			on the requirement to include		
		irector confirmed the lack of			documentation for the		
	•	the previously mentioned			transmission of the alarm to th		
	shifts and quarters				monitoring company to meet s	set	
	TEL : (* 1:	: 1 '4 4 D' 4 C			standards.		
	_	viewed with the Director of			c On 8/6/2024 the		
	_	enance Director during the exit			Administrator in-serviced the		
	conference on 07/1	1/24.			Maintenance Supervisor/design	-	
	2.1.10(1)				on the requirement to ensure		
	3.1-19(b)				drills are held on varied dates		
	3.1-51(c)				all shifts and quarters to meet	set	
	2.5.1.1				standards.		
		review and interview, the			2 ALL OTHERS WITH		
	-	sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECTI		
	_	documentation of the			a All residents and all staf		
		re alarm signal to the			and visitors have the potential	ιο	
		y/fire department during the			be affected but none were.	·	
	_	. LSC 19.7.1.4 requires fire			3 MEASURES TO PREVE	.N I	
		occupancies shall include the			REOCCURRENCE:		
		fire alarm signal and			a Maintenance	ıro	
		gency conditions. This ould affect all residents.			Supervisor/designee will ensu	i e	
	deficient practice co	build affect all fesidents.			fire drills are conducted at	50	
	Findings include:				unexpected times under varyi	-	
	rindings include.				conditions at least quarterly of		
	Raced on review of	the facility's fire drill reports			each shift and that documentation		
		en 10:15 a.m. and 4:30 p.m. with			be retained in the facility's Life Safety Binder and all reports v		
		-			have documentation for the	WIII	
	the Maintenance Director present, 3 of 8 fire drill reports performed during the past 12 month period				transmission of the alarm to the	10	
		with documentation for the			monitoring company and will	10	
	_	alarm to the monitoring			ensure fire drills are held on v	aried	
		rill dates and times include:			dates for all shifts and quarter		
		m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Preventi		
	_	d on interview at the time of			Maintenance Program and	ve	
	_	Maintenance Director			document those inspection re	culte	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF E	PROVIDER OR SUPPLIER	•	•	STREET .	ADDRESS, CITY, STATE, ZIP COD	_	
					ISTER BARBARA WAY		
WATERS	OF GEORGETON	VN, THE		GEOR	GETOWN, IN 47122		
(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 APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	e was no information on 3 of 8			as appropriate. If any issues		
		verify that transmission of the			discovered, they will be addre		
	alarm was received	by the monitoring company.			and resolved immediately. The		
					Maintenance Supervisor/desi	_	
	_	viewed with the Director of			will review with the Administra	ator	
	1	enance Director during the exit			the inspection results.		
	conference on 07/1	1/24.			b The Administrator will		
	2 1 10/1)				monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c) 3. Based on record review and interview, the				schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
	facility failed to ensure fire drills were held on varied dates for all shifts and quarters. This				4 MONITORING		
		-			CORRECTIVE ACTION:	•••	
	_	ould affect all residents in the			a The inspection results v		
	facility.				be presented by the Maintena	ance	
	E' 1' ' 1 1				Supervisor/designee to the		
	Findings include:				Administrator monthly and the)	
	D 1				Administrator will present the		
		the facility's fire drill reports			inspection results at the mont	-	
		n 10:15 a.m. and 4:30 p.m. with			Quality Assurance/Performan		
		rector present, there were			Improvement (QA/PI) meeting	-	
		ire drills performed during the od and on three occasions			Inspection results and system		
					components will be reviewed	by	
		drills performed on the same 7/24, and 05/28/24). Based on			the QA/PI Committee with	n	
	1 .	e of record review, the			subsequent plans of correction		
					developed and implemented	a S	
		for acknowledged there were solutions documented during the past			deemed necessary to ensure		
		d there were three occasions			compliance is maintained.		
		s were performed during the			This plan of correction constitutes our credible		
	same day.	s were performed during the			allegation of compliance wit	h	
	baille day.				all regulatory requirements.		
	This finding was re	viewed with the Director of			Our date of compliance is		
	_	enance Director during the exit			8/16/2024.		
	conference on 07/1	-			0/10/2024.		
	conference on 0//1	1,21.			K914 – Building 01 - It is the		
	3.1-19(b)				_		
	3.1-19(b) 3.1-51(c)				intent of the facility to ensure		
	3.1-31(6)				complete documentation is	arado	

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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 07 COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			07	COMPLETED
		155770	B. W	ING		07/11/2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
\\\\\TEDG		/N THE			ISTER BARBARA WAY	
WATERS	OF GEORGETOW	VIN, INE	•	GEUR	GETOWN, IN 47122	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	electrical receptacles in all	DATE
					resident room locations are te	sted
					at least annually to meet set	Sicu
					standards.	
					1 CORRECTIVE ACTIONS	3
					TAKEN:	
					a On 8/7/2024 the	
					Maintenance Supervisor/design	
					conducted the annual electrica	al
					receptacle inspection and	
					documented the results in the	
					facilities Life safety binder to r set standards. The Administra	
					verified repairs on 8/7/2024.	
					2 ALL OTHERS WITH	
					POTENTAL TO BE AFFECTE	D:
					a All residents and all staf	f
					and visitors have the potential	to
					be affected but none were.	
					3 MEASURES TO PREVE	NT
					REOCCURRENCE:	
					a On 8/6/2024 the	
					Administrator in-serviced the Maintenance Supervisor/design	1000
					on the requirement the annual	
					electrical receptacle inspection	
					and testing must be completed	
					annually and documented in the	
					life safety binder to meet set	
					standards.	
					b Maintenance	
					Supervisor/designee will ensu	
					the annual electrical receptacl	e
					inspection and testing is	
					completed and documented a part of the facility's Preventive	
					Maintenance Program and	
					document those inspection res	sults
					as appropriate. If any issues	
					discovered they will be addre	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG 07	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIE		100	REET ADDRESS, CITY, STATE, ZIP COD 02 SISTER BARBARA WAY EORGETOWN, IN 47122	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREF	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	ON (X5) O BE OPPRIATE COMPLETION DATE	
				and resolved immediately. Maintenance Supervisor/d will review with the Administrator results. c The Administrator with monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection result be presented by the Maint Supervisor/designee to the Administrator and the Administrator will present inspection results at the m Quality Assurance/Perform Improvement (QA/PI) meet Inspection results and system components will be review the QA/PI Committee with subsequent plans of corredeveloped and implement deemed necessary to ensicompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance is 8/16/2024.	ts will ts will tenance the onthly nance ting. tem red by ction ted as ure with tts.	
K 0914 SS=F Bldg. 07	NFPA 101 Electrical System Testing	ns - Maintenance and				

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

Testing

Electrical Systems - Maintenance and

Event ID:

OZM221

Facility ID: 011509

509

If continuation sheet Page 110 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 07 COMPLET B. WING 07/11/20			ETED		
	OF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	locations and whe anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visich LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on observation	ceptacles at patient bed are deep sedation or general hinistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not enths. Line isolation monitors are tested at intervals of to 1 month by actuating the per 6.3.2.6.3.6, which the ual and audible alarm. For the intervals less 2 months. LIM circuits are 1.2 after any repair or electric distribution system. It is a composite to modifications, from or area tested, and the failed to ensure complete.	K 09	114	K914 – Building 08 - It is the intent of the facility to ensure		08/16/2024
	documentation was nonhospital-grade or resident room locat NFPA 99, Health C Section 6.3.4.1.3 st hospital-grade, at p locations where decanesthesia is admin intervals not exceed Section 6.3.3.2, Rec Rooms requires the receptacle shall be a The continuity of the electrical receptacle	•			complete documentation is available for all non hospital gelectrical receptacles in all resident room locations are teat least annually to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 8/7/2024 the Maintenance Supervisor/design conducted the annual electrical receptacle inspection and documented the results in the facilities Life safety binder to meet set standards. The Administration is available for all provided the results in the facilities Life safety binder to meet standards. The Administration is available for all non-hospital general provided the results in the facilities Life safety binder to meet standards. The Administration is available for all non-hospital general provided to the safety binder to meet standards.	sted S Inee al	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 111 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	07	COMPL		
		155770	B. W	ING		07/11	/2024	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	FROVIDER OR SUFFLIER			1002 SI	ISTER BARBARA WAY			
WATERS	S OF GEORGETOV	VN, THE		GEORG	GETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY 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	
		ptacle shall be confirmed; and			verified repairs on 8/7/2024.			
		ne grounding blade of each			2 ALL OTHERS WITH			
	electrical receptacle (except locking-type				POTENTAL TO BE AFFECTE	D:		
	receptacles) shall be not less than 115 grams (4				a All residents and all staf	f		
	ounces). This deficient practice could affect all				and visitors have the potential	l to		
	residents.				be affected but none were.			
					3 MEASURES TO PREVE	NT		
	Findings include:				REOCCURRENCE:			
					a On 8/6/2024 the			
		view on 07/10/24 between 10:15			Administrator in-serviced the			
	_	with the Maintenance Director			Maintenance Supervisor/desig	-		
	_	no documentation available of			on the requirement the annua			
		room receptacle test for non			electrical receptacle inspectio			
		ptacles. Based on interview at			and testing must be complete	d		
		eview, the Maintenance			annually and documented in t			
		the electrical receptacles in			life safety binder to meet set			
		e not hospital-grade			standards.			
	receptacles as far as	s he knew. He further said he			b Maintenance			
		mentation to show that annual			Supervisor/designee will ensu	ıre		
		9, Receptacle Testing			the annual electrical receptac	le		
	_	net with all pertinent			inspection and testing is			
		the past 12 month period or			completed and documented a			
	_	servations on 07/11/24			part of the facility's Preventive	;		
		and 12:15 p.m. during a tour of			Maintenance Program and			
		Maintenance Director, there			document those inspection re-			
		lectrical receptacles in each			as appropriate. If any issues			
	resident room.				discovered, they will be addre			
					and resolved immediately. Th			
	_	viewed with the Director of			Maintenance Supervisor/desig	gnee		
	_	enance Director during the exit			will review with the Administra	ator		
	conference on 07/1	1/24.			the inspection results.			
					c The Administrator will			
	3.1-19(b)				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		

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			JILDING	onstruction 07	(X3) DATE : COMPL 07/11 /	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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)	TE	(X5) COMPLETION DATE
					be presented by the Maintena Supervisor/designee to the Administrator 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 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. Our date of compliance is 8/16/2024.	nly ce	
K 0918 SS=F Bldg. 07	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer lormed in accordance with le inspected weekly, load 30 minutes 12 times a intervals, and exercised other load conditions include					

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 113 of 135

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	07	COMPL	ETED
		155770	B. WI	NG		07/11/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ISTER BARBARA WAY		
WATER!	S OF GEORGETOV	VN THE			GETOWN, IN 47122		
WATER	. GEORGETOV	viv, 111 <u></u>		GLOIK	3L10WN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ated cold start and					
		ual transfer of all EES					
	· ·	nducted by competent					
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder						
		re inspected annually, and a					
	program for perio	dically exercising the					
	-	tablished according to					
	•	uirements. Written records					
		nd testing are maintained					
	1	ble. EES electrical panels					
		arked, readily identifiable,					
	· ·	n normal power circuits.					
		ssibility of damage of the					
		r source is a design					
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1						
		view and interview, the facility	K 09	918	K918 – Building 08 - It is the		08/16/2024
		complete written record of			intent of the facility to ensure		
		load testing for 1 of 1 generator			maintain a complete written re		
		12 months. Chapter			of monthly generator load test	ing	
		12 NFPA 99 requires monthly			for generator during the past		
	1 0	ator serving the emergency			twelve months to meet set		
	_	be in accordance with NFPA			standards.		
		or Emergency and Standby			1 CORRECTIVE ACTIONS	3	
	1	hapter 8. Chapter 6.4.4.2 of			TAKEN:		
	_	a written record of inspection,			a On 7/15/2024 the		
	_	ising period, and repairs for the			Maintenance Supervisor		
		ularly maintained and available			conducted the monthly load		
	for inspection by th				testing for the emergency		
	-	er 6-4.4.1.3 of 2012 NFPA 99			generator and documented th		
	_	or on-site generators shall be			results in the facilities Life Saf	-	
		rdance with NFPA 110, 2010			Binder to meet set standards.		
		or Emergency and Standby			The Administrator verified the	work	
	•	3.7 requires storage batteries,			on 7/15/2024.		
		te levels or battery voltage,			2 ALL OTHERS WITH		
		with systems shall be			POTENTIAL TO BE AFFECTI		
	inspected weekly a	nd maintained in full			a All residents and all staf	f	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			ILDING	ONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 07/11/2024		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF GEORGETOV	VN, THE			ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION anufacturer's specifications.		TAG	and visitors have the potentia	l to	DATE
		tive batteries shall be repaired			be affected but none were.	1 10	
		ately upon discovery of			3 MEASURES TO PREVE	NT	
	defects. Chapter 6.5.4.2 of NFPA 99 requires a				REOCCURRENCE:		
	written record of inspection, performance,				a On 8/6/2024 the		
	exercising period, and repairs shall be regularly				Administrator in-serviced the		
		ilable for inspection by the			Maintenance Supervisor/design	•	
		risdiction. This deficient			on the requirement to conduc	t all	
	1 -	et all residents, staff and			testing on the emergency		
	visitors.				generator including the month		
	Findings includes				testing to meet set standards.		
	Findings include:				b The Maintenance Supervisor/designee will ensu	ıro to	
	Based on review of the generator inspection and				conduct all testing on the	iie io	
		7/10/24 between 10:15 a.m. and			emergency generator includir	a the	
	~ ^	Maintenance Director present,			monthly load testing as a part	-	
	_	ly generator load test			the facility's Preventive		
		lable for June of 2024 for the			Maintenance Program and		
	emergency generate	or. Based on interview at the			document those inspection re	sults	
	time of record revie	ew, the Maintenance Director			as appropriate. If any issues	are	
	1	been in a transition period			discovered, they will be addre		
		o and the monthly load test of			and resolved immediately. The		
	the emergency gene	erator was not completed.			Maintenance Supervisor/desi	-	
	TE1 : C 1:	1 1 14 4 B			will review with the Administra	ator	
		viewed with the Director of enance Director during the exit			the inspection results.		
	conference on 07/1	_			c The Administrator will monitor adherence to the		
	conference on 07/1	1/27.			Preventative Maintenance		
	3.1-19(b)				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	nce	
					Supervisor/designee to the		
					Administrator monthly and the	•	
					Administrator will present the		
					inspection results at the mont	-	
	ī				I I III Allity / Accurance/Dertormon	00	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	07	COMPLETED
		155770	B. WI	NG		07/11/2024
	ROVIDER OR SUPPLIER			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID	SUMMARY S	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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					Improvement (QA/PI) meeting Inspection results and system components will be reviewed If 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 8/16/2024.	by n as
K 0000						
Bldg. 08	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 07/1 Facility Number: 0 Provider Number: 1 AIM Number: 2009 At this Life Safety Of Georgetown, was for Requirements for Pamedicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L	11509 155770 209280 Code survey, The Waters of bund not in compliance with carticipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the cition Association (NFPA) 101, SC), and 410 IAC 16.2. Villa with Chapter 19, Existing	of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is		the state of the s	

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 116 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 08 COMPLETED B. WING 07/11/2024			
	PROVIDER OR SUPPLIER		1002	T ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY RGETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Type V (111) const: The facility has a findetection in the corricorridors, and all re	ty was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the sident sleeping rooms. The ty of 8 and had a census of 7 sit.		considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.	
K 0345 SS=F Bldg. 08	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on record	n - Testing and m is tested and maintained n an approved program requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K345 – Building 8 - It is the intent of the facility to ensure	08/16/2024 the
	devices connected t performed. NFPA the 2010 Edition, at inspections, testing, provided that include	o 1 of 1 fire alarm system was 72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be les the following information all the applicable information 14.6.2.4:		annual testing of all devices connected to fire alarm system are performed and to maintain alarm system in accordance of NFPA 72, as required by LSC Sections 19.3.4.5.1 and 9.6 and ensure complete documentat available for the sensitivity test of all hard wired smoke detect and to show what testing instrument is used to test all	ms n fire with 0 101 nd to ion is sting

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 117 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 08	(X3) DATE SURVEY COMPLETED 07/11/2024	
		100770	<u> </u>		0171172021
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
WATERS	OF GEORGETOV	VN, THE		RGETOWN, IN 47122	
(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 APPROPRI	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		performing inspection,		smoke detectors for sensitivit	y to
		or combination thereof, and		meet set standards.	
	affiliation, business	address, and telephone		1 CORRECTIVE ACTION	S
	number			TAKEN:	
	(6) Name, address,	and representative of		a On 8/9/2024 the facilities	s
	approving agency (ies)		licensed contractor performed	d the
		he detector(s) tested		annual fire alarm system	
	(8) Functional test of			inspection / test report and	
	* *	of required sequence of		documented in the facilities L	ife
	operations			Safety Binder to meet set	
	(10) Check of all sn			standards. The Administrato	r
	(11) Loop resistanc	e for all fixed-temperature,		verified the work on 8/9/2024	
	line-type heat detec			b On 8/9/2024 the facilities	s
	(12) Functional test	of mass notification system		licensed contractor performe	d the
	control units			semi-annual visual fire alarm	
	(13) Functional test	of signal transmission to mass		system inspection and	
	notification systems			documented in the facilities L	ife
		of ability of mass notification		Safety Binder to meet set	
	-	re alarm notification appliances		standards. The Administrato	r
		gibility of mass notification		verified the work on 8/9/2024	
	system speakers			c On 8/9/2024 the facilities	s
		required by the equipment		license contractor performed	the
	manufacturer's publ			biannual sensitivity testing or	the
		required by the authority		fire alarm system smoke	
	having jurisdiction			detectors and documented th	
		ester and approved authority		results in the Life Safety Bind	er
	representative			and also documented the	
		problems identified during test		manufacturer's calibrated	
	(e.g., system owner			sensitivity test instrument from	n the
	corrected/successfu	•		fire alarm system inspection	
	abandoned in place			contractor to meet set standa	
	-	ice could affect all occupants		The Administrator verified the	work
	in the facility.			on 8/9/2024.	
				2 ALL OTHERS WITH	
	Findings include:			POTENTIAL TO BE AFFECT	
		07/10/211		a All residents and all sta	
		view on 07/10/24 between 10:15		and visitors have the potentia	ıl to
	-	with the Maintenance Director		be affected but none were.	
		was unable to provide an		3 MEASURES TO PREVI	ENT
	annual fire alarm sy	stem inspection/test report	1	REOCCURRENCE:	

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	08	COMPL	ETED
		155770	B. W	ING _		07/11/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			STER BARBARA WAY		
WATERS	OF GEORGETOV	VN THE			GETOWN, IN 47122		
	- CLONGETOV	*:*, :::I		SLOING			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	performed during the past 12 month period. The				a On 8/6/2024 the		
	most recent annual fire alarm system				Administrator in serviced the		
	inspection/test report was dated 06/14/23				Maintenance Supervisor/desig		
	performed by the facility's fire alarm system				on the requirement to ensure		
	vendor. Based on interview at the time of record				alarm systems are maintained		
		nfirmed by the Maintenance			properly including the semi-an	ınual	
	Director.				and annual fire alarm system		
					inspections and testing		
	_	eviewed with the Director of			documents to be retained in th		
		enance Director during the exit			facilities Life Safety Binder and	d to	
	conference on 07/1	1/24.			ensure the smoke detector		
	21 104)				sensitivity test of all hard wired	d	
	3.1-19(b)				smoke detectors contains the		
	A D 1				name of the manufacturer's		
		review and interview, the			calibrated sensitivity test		
	1	nintain 1 of 1 fire alarm system in			instrument to meet set standa	rds.	
		FPA 72, as required by LSC 101			b Maintenance		
		and 9.6. NFPA 72, Section			Supervisor/designee will ensu		
		nless otherwise permitted by			fire alarm systems are maintai		
	_	ections shall be performed in			properly including the semi-an	inuai	
		e schedules in Table 14.3.1, or			and annual fire alarm system		
	_	red by the authority having			inspections and testing		
	l -	14.3.1 states that the following			documents to be retained in the		
		spected semi-annually:			facilities Life Safety Binder and	a to	
	a. Control unit troub b. Remote annuncia	_			ensure the smoke detector	.1	
					sensitivity test of all hard wired	ı	
		s (e.g. duct detectors, manual			smoke detectors contains the		
		eat detectors, smoke detectors,			name of the manufacturer's		
	etc.) d. Notification appl	iances			calibrated sensitivity test instrument as a part of the		
	e. Magnetic hold-op				· · · · · · · · · · · · · · · · · · ·	000	
		ice could affect all residents,			facility's Preventive Maintenar Program and document those		
	staff, and visitors in				inspection results as appropria		
	starr, and visitors in	i die idenity.			If any issues are discovered, t		
	Findings include:				will be addressed and resolve		
	i manigo metude.		1		immediately. The Maintenance		
	Rased on record res	view on 07/10/24 between 10:15			Supervisor/designee will revie		
		with the Maintenance Director			with the Administrator the	vv	
	1	no documentation provided					
	1 -	-			inspection results.		
	regarding a seini-an	nnual visual fire alarm system	1		c The Administrator will		I

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	08	COMPL	LETED
		155770	B. W	ING		07/11	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	NN THE			GETOWN, IN 47122		
WAILING	- GLONGLION	VIN, 111L		GLOING	3L10WN, IN 47 122		
(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
		he past 12 month period. The			monitor adherence to the		
		tem inspection/test provided			Preventative Maintenance		
		for an annual fire alarm			schedule and validate the		
	inspection/test by the facility's vendor. Based on				Preventative Maintenance		
	interview at the time of record review, the				documentation is in place.		
	Maintenance Director confirmed there was no				4 MONITORING		
		inspection of the facility's fire			CORRECTIVE ACTION:		
		es performed during the past			a The inspection results w		
	12 month period.				be presented by the Maintena	nce	
					Supervisor/designee to the		
	This finding was reviewed with the Director of				Administrator and the		
		enance Director during the exit			Administrator will present the		
	conference on 07/1	1/24.			inspection results at the month	-	
					Quality Assurance/Performan		
	3.1-19(b)				Improvement (QA/PI) meeting		
					Inspection results and system		
		I review and interview, the			components will be reviewed	by	
	-	sure complete documentation			the QA/PI Committee with		
		ne sensitivity testing of all hard			subsequent plans of correctio		
		tors, and to show what testing			developed and implemented a	as .	
		d to test all smoke detectors			deemed necessary to ensure		
		PA 72, National Fire Alarm			compliance is maintained.		
	· ·	n, Section 14.4.5.3.1 states			This plan of correction		
	-	shall be checked within 1 year			constitutes our credible		
		every alternate year thereafter.			allegation of compliance wit	Л	
		quired calibration test, if			all regulatory requirements.		
		licate that the detector has slisted and marked sensitivity			Our date of compliance is		
		f time between calibration tests			8/16/2024.		
		to be extended to a maximum of					
	_	uency is extended, records of					
		sance alarms and subsequent					
		ms shall be maintained. In					
		re nuisance alarms show an					1
	increase over the previous year, calibration tests shall be performed. To ensure that each smoke						
	_	ts listed and marked sensitivity					
		sted using any of the methods:					
	(1) Calibrated test						
	1 '	calibrated sensitivity test					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	î í	UILDING	nstruction <u>08</u>	(X3) DATE COMPL 07/11 /	LETED	
	PROVIDER OR SUPPLIER S OF GEORGETOV		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	purpose. (4) Smoke detector, arrangement where at the control unit vits listed sensitivity (5) Other calibrated to the authority have Detectors found to listed and marked scleaned and recalib The detector sensition measured using any an unmeasured con	I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be						
	residents, staff, and Findings include:	visitors in the facility.						
	a.m. and 4:30 p.m. present, there was a show a smoke detect wired smoke detect by the facility's fire vendor, however, the name of the manufatest instrument. The Maintenance Direct This finding was re	with the Maintenance Director documentation available to ctor sensitivity test of all hard cors was performed on 06/14/23 alarm system inspection he report did not include the acturer's calibrated sensitivity is was confirmed by the tor at the time of record review. Viewed with the Director of the enance Director during the exit 1/24.						
	3.1-19(b)							
K 0353 SS=F Bldg. 08		- Maintenance and Testing - Maintenance and Testing						

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 121 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	r í	ILDING	08	COMPL	
		155770	B. WI	NG		07/11	/2024
		1	 -	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R	l		ISTER BARBARA WAY		
WATERS	S OF GEORGETOV	VN, THE			GETOWN, IN 47122		
(X4) ID	Г	STATEMENT OF DEFICIENCIE		ID	· [(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	'	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		er and standpipe systems		1110			DATE
		sted, and maintained in					
		NFPA 25, Standard for the					
		ng, and Maintaining of					
	I -	Protection Systems.					
		n design, maintenance,					
	I	sting are maintained in a					
		nd readily available.					
		r system last checked					
	b) Who provided	I system test					
	c) Water system	supply source					
	Provide in REMA	RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8						
		I review and interview, the	K 03	353	K353 – Building 08 It is the ir	ntent	08/16/2024
	facility failed to pro	ovide written documentation or			of the facility to ensure to pro		
	other evidence the	sprinkler system components			written documentation or other	er	
	had been inspected	and tested for 1 of 4 quarters			evidence the sprinkler system	1	
	for 1 of 1 sprinkler	system. LSC 4.6.12.1 requires			components have been inspe	cted	
		nent or system required for			and tested for 1 of 4 quarters	for	
		is Code be maintained in			the sprinkler system and to		
		pplicable NFPA requirements.			ensure to document sprinkler		
		shall be properly maintained in			system inspections in accorda		
		FPA 25, Standard for the			with NFPA 25 the dry sprinkle		
		, and Maintenance of			system's pressure gauges an		
		Protection Systems. NFPA 25,			during 10 of the past 12 mont		
		rds shall be made for all			for the sprinkler system's con		
	_	and maintenance of the system			valves to meet set standards.		
	_	all be made available to the			1.CORRECTIVE ACTIONS		
		risdiction upon request. 4.3.2			TAKEN:		
	_	ls shall indicate the procedure			1.On 8/9/2024 the faciliti	es	
	1	spection, test, or maintenance),			licensed sprinkler contractor		
	_	at performed the work, the e. NFPA 25, 5.2.5 requires that			performed the quarterly sprint		
	· ·	evices shall be inspected			inspection and documented the		
		they are free of physical			results in the facilities Life Sa	-	
	quarterry to verify	mey are nee or physical			Binder to meet set standards.		I

OZM221

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPL	ETED
		155770	B. W	ING		07/11/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATERS	S OF GEORGETON	VN. THE			GETOWN, IN 47122		
	T				, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG				TAG		a.ule	DATE
	_	5, 5.3.3.1 requires the mechanical evices including, but not limited			The Administrator verified the on 8/9/2024.	e work	
		ngs, shall be tested quarterly.			2.On 7/31/2024 the		
	_	ne-type and pressure			Maintenance Supervisor perf	formed	
	_	low alarm devices shall be			the weekly inspection of the	omeu	
		y. This deficient practice could			facilities dry sprinkler system		
	1	staff, and visitors in the			gauges and documented the		
	facility.	starr, and visitors in the			results in the facility life safet		
	lucinty.				binder to meet set standards.	•	
	Findings include:				Administrator verified the wor		
	i manigs merade.				7/31/2024.	IK OII	
	Based on review of	f the quarterly sprinkler system			3.On 7/31/2024 the		
		on 07/10/24 between 10:15 a.m.			Maintenance Supervisor perf	ormed	
	_	the Maintenance Director			the monthly inspection of the		
	•	no quarterly sprinkler system			facilities sprinkler system cor		
	_	vailable for the second quarter			valves and documented the r		
		ine) of 2024. Based on			in the facility life safety binde	r to	
	interview at the tin	ne of record review, the			meet set standards. The		
	Maintenance Direc	tor confirmed there was no			Administrator verified the wor	rk on	
	written documenta	tion available to show the			7/31/2024 .		
	sprinkler system ha	nd been inspected during the			2.ALL OTHERS WITH		
	second quarter of 2	2024.			POTENTIAL TO BE AFFECT	ED:	
					1.All residents and all st	aff	
	1	eviewed with the Director of			and visitors have the potentia	al to	
	_	enance Director during the exit			be affected but none were.		
	conference on 07/1	1/24.			3.MEASURES TO PREVEN	١T	
					REOCCURRENCE:		
	3.1-19(b)				1.On 8/6/2024 the		
					Administrator in serviced the		
		l review, observation, and			Maintenance Supervisor/desi	-	
		ity failed to document sprinkler			on the requirement to ensure	;	
		in accordance with NFPA 25			sprinkler inspections are		
		kler system during 47 of the			conducted and documented	l	
	_	he sprinkler system's pressure			including the quarterly sprink		
	1	10 of the past 12 months for			inspection, weekly inspection	ı ot	
	the sprinkler system's control valves. NFPA 25,				the gauges and the monthly	4 -	
	Standard for the Inspection, Testing, and				inspection of the control valves to		
	Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states				meet set standards.		
	_ ·				2.Maintenance		
	gauges on dry pipe	gauges on dry pipe sprinkler systems shall be			Supervisor/designee will ensi	ure	Ī

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPL	ETED
		155770	B. W	ING		07/11/	2024
				CTREET	ADDRESS STEW STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\/\TED		AN THE					
WATERS	OF GEORGETOW	VIN, THE		GEORG	GETOWN, IN 47122		
(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' DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	inspected weekly to	ensure that normal air and			sprinkler inspections are		
	water pressures are	being maintained. Section			conducted and documented		
	5.1.2 states valves a	and fire department			including the quarterly sprinkle	er	
	connections shall be	e inspected, tested, and			inspection, weekly inspection	of	
	maintained in accor	dance with Chapter 13.			the gauges and the monthly		
	Section 13.1.1.2 sta	tes Table 13.1.1.2 shall be			inspection of the control valves	s as	
		on, testing and maintenance of			a part of the facility's Preventiv	/e	
		onents and trim. Section 4.3.1			Maintenance Program and		
		be made for all inspections,			document those inspection res	sults	
		nce of the system and its			as appropriate. If any issues	are	
	1 -	all be made available to the			discovered, they will be addres	ssed	
		risdiction upon request. This			and resolved immediately. Th	е	
		ould affect all residents, staff,			Maintenance Supervisor/desig	jnee	
	and visitors in the fa	acility.			will review with the Administra	tor	
					the inspection results.		
	Findings include:				3.The Administrator will		
					monitor adherence to the		
		review on 07/10/24 between			Preventative Maintenance		
		p.m. with the Maintenance			schedule and validate the		
	_	ere was no documentation			Preventative Maintenance		
		ne facility's dry sprinkler			documentation is in place.		
		e inspected weekly during 47			4.MONITORING CORRECTI	VE	
	_	period. The only weekly			ACTION:		
		pections were for the weeks in			1.The inspection results v		
	1	24. Based on interview at the			be presented by the Maintena	nce	
		ew, the Maintenance Director			Supervisor/designee to the		
		s no documentation available			Administrator monthly and the		
		ility's sprinkler gauges have			Administrator will present the		
		ast weekly during 47 of the			inspection results at the month	-	
	_	ed on observations on			Quality Assurance/Performand		
		:45 a.m. and 12:15 p.m. during a			Improvement (QA/PI) meeting		
	I	with the Maintenance Director			Inspection results and system		
	I	pressure gauges at the			components will be reviewed by	ру	
	sprinkler riser.				the QA/PI Committee with		
		07/10/211			subsequent plans of correction		
		review on 07/10/24 between			developed and implemented a	IS	
		p.m. with the Maintenance			deemed necessary to ensure		
	Director present, there was no monthly sprinkler		compliance is maintained.				
		es inspection documentation			This plan of correction		
	for 10 of the past 12	2 months. The only monthly	1		constitutes our credible		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>08</u> COMPLETED			ETED	
		155770	B. W	NG		07/11/	2024
			_	CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\\\\ATEDQ	OF GEORGETOW	/N THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
WATERS	OF GEORGETON	/N, ITIE		GEORG	3E 1 O WIN, IN 47 122		
(X4) ID	SUMMARY S	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'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	inspections available	e were for June and July of			allegation of compliance with	1	
	2024. Based on inte	erview at the time of record			all regulatory requirements.		
	review, the Mainten	ance Director confirmed the			Our date of compliance is		
	lack of sprinkler sys	stem inspections on the control			8/16/2024.		
	valves during the pa	ast 12 months.					
	This finding was rev	viewed with the Director of					
	Nursing and Mainte	enance Director during the exit					
	conference on 07/11	1/24.					
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 08	Fire Drills						
		the transmission of a fire					
	-	simulation of emergency fire					
		ills are held at expected					
	-	mes under varying					
		t quarterly on each shift.					
		r with procedures and is					
		re part of established					
		ills are conducted between					
	9:00 PM and 6:00	·					
		ay be used instead of					
	audible alarms.	0.7.4.7					
	19.7.1.4 through 1		177.0	710	K740 Bestlette e 00 It is the		00/1/6/2024
		review and interview, the	K 0	/12	K712 – Building 08 - It is the	_	08/16/2024
		vide quarterly fire drill			intent of the facility to ensure t	0	
		3 of 3 shifts during 3 of 4			provide quarterly fire drill		
	•	eient practice could affect all			documentation for 3 shifts duri	•	
		staff and visitors in the			all 4 quarters and to ensure fir	е	
	facility.				drill reports included complete	oion	
	Eindings in slude.				documentation of the transmis	sion	
	Findings include:				of a fire alarm signal to the		
	Raced on review of	the facility's fire drill reports			monitoring company/fire	alvo	
		n 10:15 a.m. and 4:30 p.m. with			department during the past two		
		rector present, the facility was			months to meet set standards. 1 CORRECTIVE ACTIONS		
		e eight documented fire drill				•	
	omy able to provide	eigni documented file diffi			TAKEN:		

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 125 of 135

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	08	COMPL	ETED
		155770	B. W	ING		07/11	/2024
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY				
WATER	S OF GEORGETOV	VN, THE			GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	1 -	12 month period. The			a On 8/6/2024 the		
	following shifts and	d quarters were missing fire drill			Administrator in-serviced the		
	reports:				Maintenance Supervisor/design	gnee	
	a. The first shift (d	ay) of the third quarter (July,			on the requirement that fire dr	ills	
	August, and Septen	nber) of 2023.			must be conducted at unexpe	cted	
	b. The second shift	(evening) of the third quarter			times under varying conditions	s at	
	(July, August, and S	September), and fourth quarter			least quarterly on each shift a	nd	
	(October, November	er, and December) of 2023, and			documented to meet set		
	first quarter (Januar	ry, February, and March) of			standards.		
	2024.				b On 8/6/2024 the		
	c. The third shift (r	night) of the third quarter (July,			Administrator in-serviced the		
	August, and Septen				Maintenance Supervisor/design	nee	
		at the time of record review,			on the requirement to include	•	
	the Maintenance Di	irector confirmed the lack of			documentation for the		
	fire drill reports for	the previously mentioned			transmission of the alarm to the	ne	
	shifts and quarters	•			monitoring company to meet s		
	•				standards.		
	This finding was re	viewed with the Director of			c On 8/6/2024 the		
	_	enance Director during the exit			Administrator in-serviced the		
	conference on 07/1	_			Maintenance Supervisor/desig	nee	
					on the requirement to ensure	-	
	3.1-19(b)				drills are held on varied dates		
	3.1-51(c)				all shifts and quarters to meet		
	3.1 31(0)				standards.	301	
	2 Based on record	review and interview, the			2 ALL OTHERS WITH		
		sure 3 of 8 fire drill reports			POTENTIAL TO BE AFFECTE	FD·	
		documentation of the					
	_	re alarm signal to the			a All residents and all state and visitors have the potential		
		y/fire department during the			be affected but none were.	. 10	
		. LSC 19.7.1.4 requires fire			3 MEASURES TO PREVE	:NT	
	1 ^	occupancies shall include the			REOCCURRENCE:	.41	
		fire alarm signal and					
		gency conditions. This				ıre	
		ould affect all residents.			Supervisor/designee will ensu fire drills are conducted at	1 C	
	deficient practice co	outa affect aff residellts.				na	
	Eindings in the J				unexpected times under varying	_	
	Findings include:				conditions at least quarterly or		
					each shift and that documenta		
		the facility's fire drill reports			be retained in the facility's Life		
	on 07/10/24 betwee	en 10:15 a.m. and 4:30 p.m. with			Safety Binder and all reports v	vill	1

the Maintenance Director present, 3 of 8 fire drill

have documentation for the

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					ISTER BARBARA WAY		
WATERS	OF GEORGETOV	VN, THE		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		during the past 12 month period			transmission of the alarm to th	ie	
	-	with documentation for the			monitoring company and will		
		alarm to the monitoring			ensure fire drills are held on v		
		rill dates and times include:			dates for all shifts and quarter		
		m., 02/27/24 at 9:45 p.m., 05/28/24			a part of the facility's Preventi	ve	
	-	d on interview at the time of			Maintenance Program and	14	
		Maintenance Director e was no information on 3 of 8			document those inspection res		
	_	verify that transmission of the			as appropriate. If any issues		
	_	by the monitoring company.			discovered, they will be addre and resolved immediately. The		
	alailii was lecelved	by the monitoring company.			Maintenance Supervisor/desig		
	This finding was re	viewed with the Director of			will review with the Administra		
		enance Director during the exit			the inspection results.	ioi	
	conference on 07/1				b The Administrator will		
	conference on 07/1	1/27.			monitor adherence to the		
	3-1.19(b)				Preventative Maintenance		
	3.1-51(c)				schedule and validate the		
	3.1 31(0)				Preventative Maintenance		
	Based on record	review and interview, the			documentation is in place.		
		sure fire drills were held on			4 MONITORING		
	-	shifts and quarters. This			CORRECTIVE ACTION:		
		ould affect all residents in the			a The inspection results w	ill	
	facility.				be presented by the Maintena		
	j				Supervisor/designee to the		
	Findings include:				Administrator monthly and the		
	_				Administrator will present the		
	Based on review of	the facility's fire drill reports			inspection results at the month	nly	
	on 07/10/24 betwee	en 10:15 a.m. and 4:30 p.m. with			Quality Assurance/Performand	ce	
	the Maintenance Di	irector present, there were			Improvement (QA/PI) meeting		
	eight documented f	ire drills performed during the			Inspection results and system		
	past 12 month perio	od and on three occasions			components will be reviewed I	by	
	there were two fire	drills performed on the same			the QA/PI Committee with		
	day (10/26/23, 02/2	27/24, and 05/28/24). Based on			subsequent plans of correction	n	
		e of record review, the			developed and implemented a	ıs	
		tor acknowledged there were			deemed necessary to ensure		
		s documented during the past			compliance is maintained.		
		d there were three occasions			This plan of correction		
		s were performed during the			constitutes our credible		
	same day.				allegation of compliance with	h	
			1		all regulatory requirements.		

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

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPLETED		
		155770	B. W	ING		07/11/	2024	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF F	PROVIDER OR SUPPLIER	ę.		1002 S	ISTER BARBARA WAY			
WATERS	OF GEORGETOV	VN, THE		GEOR	GETOWN, IN 47122			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
	_	viewed with the Director of			Our date of compliance is			
	conference on 07/1	enance Director during the exit			8/16/2024.			
	conference on 07/1	1/24.			K014 Building 01 It is the			
	3.1-19(b)				K914 – Building 01 - It is the intent of the facility to ensure			
	3.1-51(c)				complete documentation is			
	3.1-31(0)				available for all non hospital	arado		
					electrical receptacles in all	J. auc		
					resident room locations are te	sted		
					at least annually to meet set	2.04		
					standards.			
					1 CORRECTIVE ACTIONS	S		
					TAKEN:			
					a On 8/7/2024 the			
					Maintenance Supervisor/design	gnee		
					conducted the annual electric	al		
					receptacle inspection and			
					documented the results in the			
					facilities Life safety binder to r	neet		
					set standards. The Administra	ator		
					verified repairs on 8/7/2024.			
					2 ALL OTHERS WITH			
					POTENTAL TO BE AFFECTE			
					a All residents and all staf			
					and visitors have the potential	to		
					be affected but none were.	:NIT		
					3 MEASURES TO PREVE	I IVI I		
					REOCCURRENCE: a On 8/6/2024 the			
					Administrator in-serviced the			
					Maintenance Supervisor/design	nnee		
					on the requirement the annua			
					electrical receptacle inspectio			
					and testing must be complete			
					annually and documented in t			
					life safety binder to meet set			
					standards.			
					b Maintenance			
					Supervisor/designee will ensu	re		
					the annual electrical receptac			

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>08</u>	(X3) DATE SURVE COMPLETED 07/11/2024	Y
	ROVIDER OR SUPPLIE		1002 S	ADDRESS, CITY, STATE, ZIP CO ISTER BARBARA WAY GETOWN, IN 47122	D	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE COM	(X5) PLETION DATE
				inspection and testing is completed and docume part of the facility's Previous Maintenance Program a document those inspect as appropriate. If any i discovered, they will be and resolved immediate Maintenance Superviso will review with the Admithe inspection results. The Administrator monitor adherence to the Preventative Maintenance Schedule and validate the Preventative Maintenance documentation is in place 4 MONITORING CORRECTIVE ACTION a The inspection results and the Administrator and the Administrator will present inspection results at the Quality Assurance/Perform Inspection results and so components will be revithe QA/PI Committee where the QA/PI Committ	nted as a rentive and ion results ssues are addressed aly. The tr/designee inistrator will e ce ne ce ce ce.	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 129 of 135

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 08 COMPLETED B. WING 07/11/2024				ETED	
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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)	ΓE	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 08	Testing Electrical Systems Testing Hospital-grade reconstructions and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not ling these locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visual LIM circuits with a manual test is perthan or equal to 12 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99)	s - Maintenance and s - Maintenance and ceptacles at patient bed are deep sedation or general cinistered, are tested after replacement or servicing. is performed at intervals cented performance data. sted as hospital-grade at the tested at intervals not noths. Line isolation monitors hare tested at intervals of to 1 month by actuating the per 6.3.2.6.3.6, which hal and audible alarm. For hal and audible alarm. For hal and audible alarm. For hal and audible alarm are hal and audible alarm. For hal and audible alarm are hal and audible alarm. For hal and audible alarm are hal and audib	L O	914	K914 – Building 08 - It is the		08/16/2024
	interview; the facili documentation was nonhospital-grade e resident room locat NFPA 99, Health C Section 6.3.4.1.3 sta hospital-grade, at pa locations where dee	ty failed to ensure complete	KO	71 4	intent of the facility to ensure complete documentation is available for all non hospital gelectrical receptacles in all resident room locations are test at least annually to meet set standards. 1 CORRECTIVE ACTIONS	sted	08/16/2024

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 130 of 135

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPLETED	
		155770	B. W	ING		07/11/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATERS	S OF GEORGETON	WN, THE			GETOWN, IN 47122		
	T						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ding 12 months. Additionally, eceptacle Testing in Patient Care			a On 8/7/2024 the	anco	
	1	e physical integrity of each			Maintenance Supervisor/desiconducted the annual electric	-	
	_	confirmed by visual inspection.				al	
	_	he grounding circuit in each			receptacle inspection and documented the results in the		
	1	e shall be verified. Correct			facilities Life safety binder to		
	_	and neutral connections in			set standards. The Administr		
		eptacle shall be confirmed; and			verified repairs on 8/7/2024.	aiUi	
		he grounding blade of each			2 ALL OTHERS WITH		
		e (except locking-type			POTENTAL TO BE AFFECTE	-n.	
	_	be not less than 115 grams (4			a All residents and all stat		
		eient practice could affect all			and visitors have the potentia	-	
	residents.	rent practice could affect an			be affected but none were.	110	
	Testaents.				3 MEASURES TO PREVE	NT	
	Findings include:				REOCCURRENCE:	-141	
	I mumgs moreure				a On 8/6/2024 the		
	Based on record re	view on 07/10/24 between 10:15			Administrator in-serviced the		
		with the Maintenance Director			Maintenance Supervisor/desi	anee	
	_	no documentation available of			on the requirement the annua	-	
	_	room receptacle test for non			electrical receptacle inspection		
		eptacles. Based on interview at			and testing must be complete		
		review, the Maintenance			annually and documented in t		
		the electrical receptacles in			life safety binder to meet set		
		re not hospital-grade			standards.		
	receptacles as far a	s he knew. He further said he			b Maintenance		
	could not find docu	amentation to show that annual			Supervisor/designee will ensu	ıre	
	testing per NFPA 9	99, Receptacle Testing			the annual electrical receptac	le	
	requirements was r	net with all pertinent			inspection and testing is		
	information within	the past 12 month period or			completed and documented a	is a	
	prior. Based on ob	servations on 07/11/24			part of the facility's Preventive	e	
	between 9:45 a.m.	and 12:15 p.m. during a tour of			Maintenance Program and		
	the facility with the	e Maintenance Director, there			document those inspection re	sults	
	were at least four e	electrical receptacles in each			as appropriate. If any issues		
	resident room.				discovered, they will be addre	essed	
					and resolved immediately. Tl	ne	
	_	eviewed with the Director of			Maintenance Supervisor/desi	gnee	
	_	enance Director during the exit			will review with the Administra	ator	
	conference on 07/1	1/24.			the inspection results.		
					c The Administrator will		
	3.1-19(b)				monitor adherence to the		

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 08	(X3) DATE SURVEY COMPLETED 07/11/2024
	PROVIDER OR SUPPLIER		1002 \$	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
				Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results be presented by the Mainten Supervisor/designee to the Administrator and the Administrator will present the inspection results at the more Quality Assurance/Performa Improvement (QA/PI) meeting Inspection results and syste components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained. This plan of correction constitutes our credible allegation of compliance wall regulatory requirements Our date of compliance is 8/16/2024.	nance e nthly nce ng. m d by fon l as e
K 0918 SS=F Bldg. 08	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer			

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

Event ID:

OZM221

Facility ID: 011509

If continuation sheet

Page 132 of 135

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL	COMPLETED	
		155770	B. WING		07/11/	07/11/2024	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
WATERS OF GEORGETOWN, THE				GEORGETOWN, IN 47122			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		ormed in accordance with					
	NFPA 110.						
		re inspected weekly,					
	exercised under load 30 minutes 12 times a						
		intervals, and exercised					
	-	onths for 4 continuous hours.					
		nder load conditions include					
		ated cold start and ual transfer of all EES					
		nducted by competent					
		·					
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in						
		NFPA 111. Main and feeder					
	circuit breakers are inspected annually, and a program for periodically exercising the						
	components is established according to						
	-	uirements. Written records					
		nd testing are maintained					
	and readily available. EES electrical panels						
		narked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
	emergency power	r source is a design					
	consideration for	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10 (NFPA 70)						
		view and interview, the facility	K 0	918	K918 – Building 08 - It is the		08/16/2024
		complete written record of			intent of the facility to ensure t		
		load testing for 1 of 1 generator			maintain a complete written re		
		t 12 months. Chapter			of monthly generator load test	ing	
	, ,	12 NFPA 99 requires monthly			for generator during the past		
		rator serving the emergency			twelve months to meet set		
		be in accordance with NFPA			standards.		
	·	or Emergency and Standby			1 CORRECTIVE ACTIONS	>	
	-	hapter 8. Chapter 6.4.4.2 of a written record of inspection,			TAKEN:		
	_	ising period, and repairs for the			a On 7/15/2024 the		
	_	ularly maintained and available			Maintenance Supervisor conducted the monthly load		
	for inspection by the	_			testing for the emergency		
		ter 6-4.4.1.3 of 2012 NFPA 99			generator and documented the	۵	
	Janisaichon, Chapt	51 0 1.T.1.5 01 2012 NITA))			generator and documented the	-	

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

Event ID:

OZM221 Facility ID: 011509

If continuation sheet Page 133 of 135

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTI			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>08</u>		08	COMPLETED	
	155770		B. W	ING		07/11/2024	
NAME OF I	PROVIDER OR SUPPLIER	,	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	ROVIDEK UK SUPPLIER			1002 S	ISTER BARBARA WAY		
WATERS	OF GEORGETOW	VN, THE		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		RIATE COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)	DATE	
	_	or on-site generators shall be			results in the facilities Life Saf	ety	
	maintained in accordance with NFPA 110, 2010			Binder to meet set standards.			
	Edition, Standard for Emergency and Standby			The Administrator verified the work		work	
	Power Systems. 8.3.7 requires storage batteries,			on 7/15/2024.			
	including electrolyte levels or battery voltage,			2 ALL OTHERS WITH		-D.	
	used in connection with systems shall be			POTENTIAL TO BE AFFECTED: a All residents and all staff			
	inspected weekly and maintained in full compliance with manufacturer's specifications.						
	_	tive batteries shall be repaired		and visitors have the potential to		IU	
		ately upon discovery of			be affected but none were. 3 MEASURES TO PREVE	INT	
	_	5.4.2 of NFPA 99 requires a			3 MEASURES TO PREVE REOCCURRENCE:	IN I	
	_	spection, performance,			a On 8/6/2024 the		
		nd repairs shall be regularly			Administrator in-serviced the		
		ilable for inspection by the			Maintenance Supervisor/design	,,,,,,,	
					on the requirement to conduct		
	authority having jurisdiction. This deficient				testing on the emergency	l all	
	practice could affect all residents, staff and				generator including the month	h _v	
	visitors.					-	
	Findings includes				testing to meet set standards. b The Maintenance		
	Findings include:				Supervisor/designee will ensu	ro to	
	Pasad an raviary of the generator inspection and				conduct all testing on the	ie to	
	Based on review of the generator inspection and testing reports on 07/10/24 between 10:15 a.m. and				emergency generator includin	a the	
	4:30 p.m. with the Maintenance Director present,				monthly load testing as a part	_	
	there was no monthly generator load test				the facility's Preventive	OI	
	documentation available for June of 2024 for the				Maintenance Program and		
	emergency generator. Based on interview at the				document those inspection re	sults	
	time of record review, the Maintenance Director				as appropriate. If any issues		
		been in a transition period			discovered, they will be addre		
	_	and the monthly load test of			and resolved immediately. Th		
	the emergency generator was not completed.			Maintenance Supervisor/designee			
	and emergency generator was not completed.			will review with the Administrator			
	This finding was re	viewed with the Director of			the inspection results.		
	_	enance Director during the exit			c The Administrator will		
	conference on 07/11/24.			monitor adherence to the			
					Preventative Maintenance		
	3.1-19(b)				schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
				CORRECTIVE ACTION			

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

PRINTED: 08/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	` ·				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 8/16/2024.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OZM221 Facility ID: 011509 If continuation sheet Page 135 of 135