PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
155770		B. WING _	B. WING		R 08/19/2024		
NAME OF PROVIDER OR SUPPLIER				STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/	19/2024
WATERS (OF GEORGETOWN, THE				SISTER BARBARA WAY RGETOWN, IN 47122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS		{K 0	00}			
	Code Recertification at that exited on 07/11/2 Indiana Department of 42 CFR 483.90(a). Survey Dates: 08/19/2 Facility Number: 011/2 Provider Number: 15 AIM Number: 200909 At this PSR to the Life Waters of Georgetow with Requirements for Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSC 1002 was surveyed whealth Care Occupant This one story facility Type V (111) construct facility has a fire alarm detection in the corridors, and all residual facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility Type V (111) construct facility has a fire alarm detection in the corridors, and all residual facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility has a fire alarm detection in the corridors, and all residual facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility has a fire alarm detection in the corridors, and all residual facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility has a fire alarm detection in the corridors, and all residual facility has a capacity 10 at the time of this was a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Occupant This one story facility has a surveyed whealth Care Oc	509 5770 9280 e Safety Code survey, The n, was found in compliance r Participation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), and 410 IAC 16.2. Villa with Chapter 19, Existing ncies. was determined to be of ction and fully sprinkled. The m system with smoke lors, spaces open to the dent sleeping rooms. The of 10 and had a census of visit. ents have customary access I areas providing facility					
{K 000}	Quality Review compl INITIAL COMMENTS	leted on 08/21/24	{K 0	00}			
LABORATORY	DIRECTOR'S OR BROWINER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	-		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03 , 04 , 05 , 06 , 07 , 08			(X3) DATE SURVEY COMPLETED		
155770 B W		R WING			R		
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	0	8/19/2024		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO	TION SHOULD BE THE APPROPRIATE			
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		155770	B. WING			08/	19/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF GEORGETOWN, THE			1	002 SISTER BARBARA WAY		
WAIERS	or George Town, The			(SEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
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	_	t (PSR) to the Life Safety and State Licensure Survey					

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		155770	B. WING				٦
NAME OF PR	ROVIDER OR SUPPLIER	199770	D. WINO	5	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	19/2024
				1	002 SISTER BARBARA WAY		
WATERS	OF GEORGETOWN, THE			(GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)			(X5) COMPLETION DATE	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING _		R 08/19/2024
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	1 00/10/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE COMPLETION
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08		(X3) DATE SURVEY COMPLETED	
	155770 B. WI		B. WING			R
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE			J. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	<u> 08</u>	/19/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08		(X3) DATE SURVEY COMPLETED		
		155770	B. WING		l	R 19/2024	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	19/2024
					1002 SISTER BARBARA WAY		
WATERS (OF GEORGETOWN, THE				GEORGETOWN, IN 47122		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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	Survey Dates: 08/19/	/24					
	Facility Number: 011	500					
	Provider Number: 15						
	AIM Number: 200909						
		e Safety Code survey, The					
	with Requirements for	n, was found in compliance					
		2 CFR Subpart 483.90(a),					
		and the 2012 edition of the					
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	facility has a fire alarm	lors, spaces open to the					
		dent sleeping rooms. The					
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	at the time of this visit	t.					
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	services were sprinkle	· · · · · · · · · · · · · · · · · · ·					
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