STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING -- B. WING	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/17/24 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Emergency Preparedness survey, The Waters of Middletown Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 21. Quality Review completed on 12/18/24	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an 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 a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/17/24 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Life Safety Code survey, The Waters of	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an 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**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Blackmon	HFA	12/31/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Middletown Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 21 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage buildings and an aluminum detached storage building which was not sprinkled. Quality Review completed on 12/18/24		**with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 public restroom in the main entrance lobby was provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect residents or staff in the business office.	K 0200	**K200**– It is the intent of the facility to ensure public restroom in the main entrance lobby is provided with door latches that require only one operation to open to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 12/31/24 the Maintenance Supervisor/designee	01/06/2025

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	Findings include: Based on observations made during a tour of the facility with Maintenance Director on 12/17/24 at 11:22 a.m., the public restroom in the main entrance lobby door was equipped with an independent dead bolt in addition to the code locked doorknob. Based on interview at the time of observation, the Maintenance Director acknowledged the public restroom door having an independent dead bolt latch as well as a door handle with a latching mechanism adding that he would take care of the issue as soon as possible. This item was discussed with the Maintenance Director, Regional Maintenance Director and the facility Administrator at the exit conference on 12/17/24. 3.1-19(b)		removed one of the locks from the public restroom in the main entrance lobby door to meet set standards. The Administrator verified the work on 12/31/24 . 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 12/31/24 the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement to ensure public restroom in the main entrance lobby is provided with door latches that require only one operation to meet set standards. b Maintenance Supervisor/designee will ensure public restroom in the main entrance lobby is provided with door latches that require only one operation as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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			Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/6/25.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the	K 0324	**K324**– It is the intent of the facility to ensure to provide an approved method for returning cooking appliances to where they are when the kitchen hood extinguishing equipment is designed and installed for kitchen hood extinguishing system to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**:	01/06/2025

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	fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as residents and staff. Findings include: Based on observations made during a tour of the facility with Maintenance Director on 12/17/24 at 12:24 p.m., the six (6) burner gas grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview at the time of the observation, the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would take care of the issue as soon as possible. This item was discussed with the Maintenance Director, Regional Maintenance Director and the facility Administrator at the exit conference on 12/17/24.		a. On 12/19/24 the Maintenance Supervisor/designee put in place an approved design location on the floor and posted on the wall next to it a picture of that design location setup to meet set standards. The Administrator verified the work on 12/19/24 . **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. The Administrator in serviced the Maintenance Supervisor/Dietary Manager and all dietary staff to ensure the six-burner gas grill is provided with an approved method that would ensure the appliance is returned to an approved design location after being moved for maintenance and cleaning to meet set standards. b. The Maintenance Supervisor and Dietary Manager will ensure the six-burner gas grill is provided with an approved method that would ensure the appliance is returned to an approved design location after being moved for maintenance and cleaning as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance	

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	3.1-19(b)		Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The monitoring results will be presented by the Administrator 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 1/6/2025.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection	K 0353	**K353** – It is the intent of the facility to ensure automatic sprinkler piping systems are examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011	01/06/2025

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	Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 12/17/24 at 10:55 a.m., the Sprinkler Systems document titled "Sprinkler: Report of Inspection" sprinkler inspection dated 11/27/24 indicated the last internal pipe investigation had been conducted on 11/10/2019 and was over five years ago. During record review, the Regional Maintenance Director was asked if a more recent internal inspection had been conducted and he stated that he would call his vendor and have the paperwork sent to him as soon as possible. After a short time, the Regional Maintenance Director returned and indicated that the vendor had not done the inspection, but he had it scheduled for 12/30/24. This item was discussed with the Maintenance Director, Regional Maintenance Director and the facility Administrator at the exit conference on 12/17/24. 3.1-19(b)		edition, the standards for the inspection, testing and maintenance of water based fire protection, section 14.2.1 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 12/30/24 the facilities licensed sprinkler contractor conducted an internal pipe inspection of the sprinkler system and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 12/30/24 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 12/31/24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure sprinkler system internal pipe inspections are conducted and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure sprinkler system internal pipe inspections are conducted and documented as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they	

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			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 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 1/6/2025.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure 5 of 12 fire drills included the	K 0712	**K712** –It is the intent of the facility to ensure fire drills include the	01/06/2025

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	verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Fire Drill Report" with the Maintenance Director on 12/17/24 at 9:34 a.m., the fire drill forms for the drills conducted in January of 2024 through May of 2024 had nothing documented in the area to indicate transmission of signal was received at the alarm monitoring company. Based on interview at the time of record review, the Maintenance Director indicated the fire drills in question were conducted prior to his being employed and it must have been missed by the previous Maintenance Director. This item was discussed with the Maintenance Director, Regional Maintenance Director and the facility Administrator at the exit conference on 12/17/24. 3.1-19(b) 3.1-51(c)		transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 am and 9:00 pm for the last four quarters to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 12/18/24 the Maintenance Supervisor/ designee tested and confirmed the monitoring company received the transmission of the signal upon activation of the fire alarm system including after hour transmissions to meet set standards. On 12/18/24 the Administrator confirmed the work. 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 12/19/24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to verify the transmission of the fire alarm system is received by the monitoring company for all fire drills and tests to meet set standards. b Maintenance Supervisor/designee will ensure to verify the transmission of the fire alarm system is received by the monitoring company for all fire drills and tests as a part of the facility's monthly Preventive	

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			Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 1/6/25.**	