Ashley Blackmon

PRINTED: 01/02/2025 FORM APPROVED OMB NO. 0938-039

12/31/2024

l '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155573	A. BUILDING COMPLETED B. WING 12/17/2024			
		100070			12/11/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		CADDRESS, CITY, STATE, ZIP COD EECHWOOD AVE		
WATERS	S OF MIDDLETOW	N SKILLED NURSING FACILITY,		LETOWN, IN 47356		
(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		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg						
Diag.	An Emergency Pre	eparedness Survey was	E 0000	DISCLAIMER STATEMENT:		
		ndiana Department of Health in	L 0000	Preparation and/or execution	n	
	accordance with 42	-		of this plan of correction in		
				general, or this corrective		
	Survey Date: 12/1	7/24		action, does not constitute a admission or agreement by		
	Facility Number: (000342		facility of the facts alleged o		
	Provider Number:			conclusions set forth in this		
	AIM Number: 100	0289140		statement of deficiencies. T		
				plan of correction and speci-	fic	
	At this Emergency	Preparedness survey, The		corrective actions are prepa	red	
	Waters of Middleto	own Skilled Nursing Facility		and/or executed in complian	ice	
	was found in comp	liance with Emergency		with state and federal laws.		
		irements for Medicare and		This plan of correction		
	_	ting Providers and Suppliers, 42		constitutes a written allegati	on	
	CFR 483.73.			of substantial compliance w	ith	
				Federal Medicare and		
	_	certified beds. At the time of		Medicaid requirements.		
	the survey, the cen	sus was 21.				
	Quality Review co	mpleted on 12/18/24				
	Quality Review co.	inpicted on 12/16/24				
K 0000						
Bldg. 01						
Blug. 01	A Life Sofety Code	e Recertification and State	V 0000	DISCLAIMER STATEMENT:		
	-	was conducted by the Indiana	K 0000	Preparation and/or execution	<u> </u>	
	-	alth in accordance with 42 CFR		of this plan of correction in	.i	
	483.90(a).	in in accordance with 42 Cl K		general, or this corrective		
	105.50(u).			action, does not constitute a	ın	
	Survey Date: 12/1	7/24		admission or agreement by		
				facility of the facts alleged o		
	Facility Number: 000342			conclusions set forth in this		
	Provider Number:	155573		statement of deficiencies. T		
	AIM Number: 100	0289140		plan of correction and speci-	fic	
				corrective actions are prepa	red	
	At this Life Safety	Code survey, The Waters of		and/or executed in complian	ce	
LABORATOR	I RY DIRECTOR'S OR PRO	DVIDER/SUPPLIER REPRESENTATIVE'S SI	TITLE	(X6) DATE		

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 disclo

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
		155573	B. WING 12/17/2024				
NAME OF P	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ECHWOOD AVE		
WATERS	OF MIDDLE FOW	N SKILLED NURSING FACILITY, T	HE	MIDDL	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROUGERIC N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	Middletown Skilled	Nursing Facility was found		with state and federal laws.			
		vith Requirements for		This plan of correction			
	_	dicare/Medicaid, 42 CFR			constitutes a written allegati	on	
	-	Life Safety from Fire and the			of substantial compliance wi		
		National Fire Protection			Federal Medicare and		
) 101, Life Safety Code (LSC),			Medicaid requirements.		
	· ·	g Health Care Occupancies and			4		
	410 IAC 16.2.	Ç					
	This one-story facil	ity was determined to be of					
		ruction and fully sprinkled.					
	The facility has a fire alarm system with smoke						
		ridors, spaces open to the					
		ry-operated smoke detectors					
		ing rooms. The facility has a					
	_	nad a census of 21 at the time					
	of this visit.						
	All areas where resi	idents have customary access					
	were sprinkled and	all areas providing facility					
	services were sprinl	kled. The facility had two					
	detached wooden st	orage buildings and an					
	aluminum detached	storage building which was					
	not sprinkled.	-					
	-						
	Quality Review con	npleted on 12/18/24					
K 0200	NFPA 101						
SS=D	Means of Egress I	Requirements - Other					
Bldg. 01							
	Based on observation	on and interview, the facility	K 0	200	K200- It is the intent of the fac	cility	01/06/2025
	failed to ensure 1 of	f 1 public restroom in the main			to ensure public restroom in the	ne	
	entrance lobby was	provided with door latches			main entrance lobby is provide	ed	
		ne operation to open. LSC			with door latches that require	only	
		s complying with 7.2.1 shall be			one operation to open to meet	t set	
	permitted. 7.2.1.5.1	0.2 requires the releasing			standards.		
	mechanism shall op	en the door leaf with not more			1 CORRECTIVE ACTIONS	3	
	than one releasing of	pperation. This deficient			TAKEN:		
	practice could affec	t residents or staff in the			a On 12/31/24 the		
	business office.				Maintenance Supervisor/desig	gnee	

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

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					` ′	3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155573	B. WING 12/17/2024				2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8			ECHWOOD AVE			
WATERS	OF MIDDLETOWN	N SKILLED NURSING FACILITY, 1	ГНЕ		ETOWN, IN 47356			
(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	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE	
					removed one of the locks from	n the		
	Findings include:				public restroom in the main			
					entrance lobby door to meet s			
		ons made during a tour of the			standards. The Administrator			
		enance Director on 12/17/24 at			verified the work on 12/31/24			
	_	lic restroom in the main			2 ALL OTHERS WITH			
		r was equipped with an			POTENTIAL TO BE AFFECTE			
	-	olt in addition to the code			a All residents and all staff			
		ased on interview at the time			and visitors have the potential	to		
	· · · · · · · · · · · · · · · · · · ·	Maintenance Director			be affected but none were.			
		oublic restroom door having an			3 MEASURES TO PREVE	NT		
	*	olt latch as well as a door			REOCCURRENCE:			
		ng mechanism adding that he			a On 12/31/24 the			
	would take care of t	the issue as soon as possible.	Administrator in serviced the					
	and the state of t	a da a set :			Maintenance Supervisor/desig	gnee		
		assed with the Maintenance			and all other staff on the			
		Maintenance Director and the			requirement to ensure public			
		or at the exit conference on			restroom in the main entrance			
	12/17/24.				lobby is provided with door late			
	2.1.10(1)				that require only one operation	n to		
	3.1-19(b)				meet set standards.			
					b Maintenance			
					Supervisor/designee will ensu	re		
					public restroom in the main	_		
					entrance lobby is provided wit			
					door latches that require only			
					operation as a part of the facil	-		
					Preventive Maintenance Progr			
					and document those inspectio			
					results as appropriate. If any			
			1		issues are discovered, they wind addressed and resolved	ııı n c		
					immediately. The Maintenanc			
					Supervisor/designee will revie			
			1		with the Administrator the	٧٧		
					inspection results.			
					c The Administrator will			
					monitor adherence to the			
					Preventative Maintenance			
					schedule and validate the			

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES					B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155573	B. W	ING		12/17/	/2024
		• -	•	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		981 BE	ECHWOOD AVE		
WATERS	S OF MIDDLETOW	N SKILLED NURSING FACILITY,	THE	MIDDL	ETOWN, IN 47356		
(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
					Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the	- l. <i>.</i>	
					inspection results at the month	•	
					Quality Assurance/Performand Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I		
					the QA/PI Committee with	Jy	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure	.0	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.	-	
					Our date of compliance is		
					1/6/25.		
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01							
		on and interview, the facility	K 0	324	K324– It is the intent of the fac	-	01/06/2025
	_	approved method for			to ensure to provide an approv	∕ed	
		appliances to where they were			method for returning cooking		
		ood extinguishing equipment			appliances to where they are		
	_	nstalled for 1 of 1 kitchen hood			the kitchen hood extinguishing	J	
		m. NFPA 96, Standard for			equipment is designed and		
		and Fire Protection of			installed for kitchen hood		
		ng Operations Section 2011			extinguishing system to meet	set	
	Landon Section 12.	1.2.2, states cooking appliances	ı		standards.		I

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requiring protection shall not be moved, modified,

or rearranged without prior re-evaluation of the

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TAKEN:

1. CORRECTIVE ACTIONS

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 12/17/2024		
		155575	D. W.		_	12/17/	72024
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					ECHWOOD AVE		
WATERS	S OF MIDDLETOWN	N SKILLED NURSING FACILITY, 1	HE	MIDDLE	ETOWN, IN 47356		
(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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
		ystem by the system installer			a. On 12/19/24 the Maintena	nce	
		unless otherwise allowed by			Supervisor/designee put in pla	ace	
	_	e extinguishing system.			an approved design location of		
		ites the fire-extinguishing			floor and posted on the wall no	ext	
		quire reevaluation where the			to it a picture of that design		
		are moved for the purposes of			location setup to meet set		
		eaning, provided the			standards. The Administrator		
		ned to approved design			verified the work on 12/19/24		
	_	oking operations, and any			2. ALL OTHERS WITH		
		xtinguishing system nozzles			POTENTIAL TO BE AFFECTE		
		iances are reconnected in			a. All residents and all staff a		
		e manufacturer's listed design			visitors have the potential to b	е	
		.1.2.3.1 states an approved			affected but none were.		
	_	ovided that will ensure that the	3. MEASURES TO PREVENT				
		d to an approved design	REOCCURRENCE:				
		ient practice could affect as			a. The Administrator in service	ed	
	many as residents a	nd staff.		the Maintenance			
	Findings in the fact				Supervisor/Dietary Manager a	ina	
	Findings include:				all dietary staff to ensure the		
	D				six-burner gas grill is provided		
		ons made during a tour of the enance Director on 12/17/24 at		an approved method that would			
	_	(6) burner gas grill which was			ensure the appliance is returned to an approved design location after		
	_	ing line under the hood in the			being moved for maintenance		
		wided with an approved			cleaning to meet set standard		
		ensure that the appliance was			b. The Maintenance Supervisor		
		oved design location after it			and Dietary Manager will ensu		
		r maintenance and cleaning.			the six-burner gas grill is provi		
		at the time of the observation,	I I		with an approved method that		
		rector stated that he was not	I I		would ensure the appliance is		
		method should be provided to			returned to an approved design		
		iance was returned to an			location after being moved for		
		cation after maintenance or			maintenance and cleaning as		
	cleaning and that he would take care of the issue				part of the facility's monthly		
	as soon as possible.			Preventive Maintenance P		ram	
					and document those inspection		
	This item was discu	issed with the Maintenance			results as appropriate. If any		
	Director, Regional	Maintenance Director and the			issues are discovered, they w		
		or at the exit conference on	addressed and resolved				
	12/17/24.				immediately. The Maintenand	е	

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ENTERS FOR MEDICARE & MEDIC.	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 <u>01</u>	COMPLETED
	155573	B. WING	12/17/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE

WATER	WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE 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			
	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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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 B. WING 12/17/2024 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (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 Systems, Section 14.2.1. Section 14.2.1 states, edition, the standards for the "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection, testing and inspection of piping and branch line conditions maintenance of water based fire protection, section 14.2.1 to meet shall be conducted every 5 years by opening a flushing connection at the end of one main and by set standards. removing a sprinkler toward the end of one branch **1.CORRECTIVE ACTIONS** line for the purpose of inspecting for the presence TAKEN: of foreign organic and inorganic material. This 1.On 12/30/24 the facilities deficient practice affects all residents, staff and licensed sprinkler contractor visitors. conducted an internal pipe inspection of the sprinkler system Findings include: and documented the results in the facilities Life Safety Binder to Based on record review with the Maintenance meet set standards. The Director on 12/17/24 at 10:55 a.m., the Sprinkler Administrator verified the work on Systems document titled "Sprinkler: Report of 12/30/24. Inspection" sprinkler inspection dated 11/27/24 2.ALL OTHERS WITH indicated the last internal pipe investigation had POTENTIAL TO BE AFFECTED: been conducted on 11/10/2019 and was over five 1.All residents and all staff years ago. During record review, the Regional and visitors have the potential to Maintenance Director was asked if a more recent be affected but none were. internal inspection had been conducted and he **3.MEASURES TO PREVENT** stated that he would call his vendor and have the REOCCURRENCE: paperwork sent to him as soon as possible. After 1.On 12/31/24 the a short time, the Regional Maintenance Director Administrator in serviced the returned and indicated that the vendor had not Maintenance Supervisor/designee done the inspection, but he had it scheduled for on the requirement to ensure 12/30/24. sprinkler system internal pipe inspections are conducted and This item was discussed with the Maintenance documented to meet set Director, Regional Maintenance Director and the standards. facility Administrator at the exit conference on 2.Maintenance 12/17/24. Supervisor/designee will ensure sprinkler system internal pipe 3.1-19(b) inspections are conducted and documented as a part of the facility's Preventive Maintenance Program and document those

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inspection results as appropriate. If any issues are discovered, they

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	ľ	UILDING	onstruction 01	(X3) DATE COMPI 12/17	LETED
	PROVIDER OR SUPPLIEI	N SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356	•	
(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)	ATE	(X5) COMPLETION DATE
					will be addressed and resolve immediately. The Maintenand 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 CORRECT ACTION: 1. The inspection results be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the mont 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 1/6/2025.	ce ew IVE will ance hly ce g. by n	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						
		view and interview, the facility f 12 fire drills included the	K 0	712	K712 –It is the intent of the fa to ensure fire drills include the	•	01/06/2025

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01/02/2025 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 B. WING 12/17/2024 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE verification of transmission of the fire alarm signal transmission of the fire alarm to the monitoring station in fire drills conducted signal to the monitoring station in between 6:00 a.m. and 9:00 p.m. for the last 4 fire drills conducted between 6:00 quarters. LSC 19.7.1.4 requires fire drills in health am and 9:00 pm for the last four care occupancies shall include the transmission of quarters to meet set standards. a fire alarm signal and simulation of emergency fire **CORRECTIVE ACTIONS** conditions. This deficient practice affects all TAKEN: residents in the facility as well as staff and On 12/18/24 the visitors. Maintenance Supervisor/ designee tested and confirmed the Findings include: monitoring company received the transmission of the signal upon Based on record review of titled "Fire Drill Report" activation of the fire alarm system with the Maintenance Director on 12/17/24 at 9:34 including after hour transmissions a.m., the fire drill forms for the drills conducted in to meet set standards. On January of 2024 through May of 2024 had nothing 12/18/24 the Administrator documented in the area to indicate transmission of confirmed the work. signal was received at the alarm monitoring **ALL OTHERS WITH** company. Based on interview at the time of record POTENTIAL TO BE AFFECTED: review, the Maintenance Director indicated the All residents and all staff fire drills in question were conducted prior to his and visitors have the potential to being employed and it must have been missed by be affected but none were. the previous Maintenance Director. **MEASURES TO PREVENT** REOCCURRENCE: This item was discussed with the Maintenance On 12/19/24 the Director, Regional Maintenance Director and the Administrator in serviced the facility Administrator at the exit conference on Maintenance Supervisor/designee 12/17/24. on the requirement to ensure to verify the transmission of the fire 3.1-19(b) alarm system is received by the 3.1-51(c)monitoring company for all fire drills and tests to meet set standards. 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

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

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 12/17/2024				ETED
NAME OF D	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ECHWOOD AVE		
WATERS	OF MIDDLETOWN	N SKILLED NURSING FACILITY, T	HE	MIDDLE	ETOWN, IN 47356		
(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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Maintenance Program and		
					document those inspection res		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra	tor	
					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		
					4 MONITORING CORRECTIVE ACTION:		
					a The fire drill documentat	ion	
					will be presented by the	1011	
					Maintenance Supervisor/desig	inee	
					to the Administrator monthly a		
					the Administrator will present t		
					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	า	
					developed and implemented a	S	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	า	
					all regulatory requirements.		
					Our date of compliance is		
					1/6/25.		

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