STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155233	A. BUILDING -- B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

(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: 02/25/25 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 At this Emergency Preparedness survey, The Waters of Batesville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 86 certified beds. At the time of the survey, the census was 56. Quality Review completed on 02/28/25	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: 02/25/25 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 At this Life Safety Code survey, The Waters of Batesville was found not in compliance with	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 with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jalena Ball	Administrator	03/12/2025

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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	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 (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 56 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the two story detached maintenance/laundry building. Quality Review completed on 02/28/25		**This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview; the facility failed to install exit signage in 1 of 1 corridor exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect up to 20 residents.	K 0293	**K293**– It is the intent of the facility to ensure to install exit signage in corridor exits in accordance with LSC 7.10 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On __March 6, 2025 _____ the Maintenance Supervisor/designee installed directional signage at the exit near resident room #49 to meet set standards. The Administrator verified the work on _____ March 6, 2025 _____ .	03/11/2025

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	Findings include: Based on observations and interview on 02/25/25 between 2:30 p.m. and 4:45 p.m. during a tour of the facility with the Administrator (AD) and Maintenance Director (MD), exit near resident room # 49 lacked directional signage once exiting the facility. The aforementioned exit discharge had options when exiting (right or left). There was no directional signage present to indicate which path was the desired path to a parking lot or the public way. One choice leads around the building and terminates at an entrance door back into the facility. The Maintenance Director agreed that the exit needs to have directional signage as only one of the two paths is part of the exit discharge. This finding was acknowledged by the AD and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)		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 _____ March 6, 2025 _____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure exit signage is present in corridor exits to meet set standards. b Maintenance Supervisor/designee will ensure exit signage is present in corridor exits as a part of the facility's monthly Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			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** _____ 03/11/2025 _____.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 2 residents, as well as staff and visitors. Findings include: Based on observations and interview on 02/25/25 between 2:30 p.m. and 4:45 p.m. during a tour of the facility with the Administrator (AD) and Maintenance Director (MD), the shower room across from resident room number 12, greater than 50 square feet contained a number of combustible items, such as 16 large cardboard boxes and a wooden pallet. The corridor door to this shower room did not self-close and latch into the door frame. The AD stated that the shower room will need to be cleaned out and it is not normally used for storage.	K 0321	**K321**– It is the intent of the facility to ensure hazardous area doors, such as storage rooms, are provided with properly working self-closing devices to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On _____ March 6, 2025 _____ the Maintenance Supervisor/Housekeeping Supervisor/designee removed the combustible items including cardboard boxes and a wooden pallet from the shower room located across from resident room number 12 to meet set standards. The Administrator verified the work on _____ March 6, 2025 _____ . **2 ALL OTHERS WITH**	03/11/2025

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	This finding was acknowledged by the AD and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)		**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 _____ March 6, 2025 _____ the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement to ensure hazardous areas are equipped with a self-closing door to meet set standards. b Maintenance Supervisor/designee will ensure hazardous areas are equipped with a self-closing door as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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			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** _____03/11/2025 _____**.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 therapy room corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 6 residents. Findings include: Based on observations and interview on 02/25/25 between 2:30 p.m. and 4:45 p.m. during a tour of the facility with the Administrator (AD) and Maintenance Director (MD) the corridor door to the Therapy Room was propped open with a weight. Based on interview at the time of observation, the MD acknowledged the aforementioned corridor door would not close unless the weight was moved first. No residents or staff were around the therapy area at the time of	K 0363	**K363** – It is the intent of the facility to ensure corridor doors are provided with a means suitable for keeping the doors closed, have no impediment to closing and latching and will resist the passage of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On _____ March 11, 2025 _____ the Maintenance Supervisor/designee removed the weight that was propping the door open to the therapy room to meet set standards. The Administrator verified the repair on _____March 11, 2025 _____ . **2 ALL OTHERS WITH**	03/11/2025

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	observation. This finding was acknowledged by the AD and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)		**POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all doors and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On ____ March 11, 2025 _____ the Administrator in serviced the Maintenance Supervisor/All staff on the requirement to ensure corridor doors have no impediments to closing and latching to meet set standards. b Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure corridor doors close and latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will	

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			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** _____ March 11, 2025 _____.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical	K 0921	**K921** – It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On _____March 06, 2025 _____ the facilities trained Regional Property Manager will conduct PCREE testing on the other PCREE in the facility	03/11/2025

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	appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and facility tour with the Administrator (AD) and Maintenance Director (MD) on 02/25/25 between 10:30 a.m. and 4:45 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The AD stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the AD and MD stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the AD and MD at the time of discovery and again at the exit conference with each present.		including: electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator verified the work on _____ _____ March 06, 2025 _____ . **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 _____March 06, 2025 _____ the Administrator inserviced the Maintenance Supervisor/designee to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards. 2.Maintenance Supervisor/designee will ensure testing of the PCREE is conducted and documented on all PCREE equipment as a part of the facility's annual 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. 3.The Administrator will monitor adherence to the Preventative Maintenance	

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	3.1-19(b)		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 ____** March 11, 2025 **_____.**	