STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING -- B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

(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(s): 04/01/25 & 04/02/25 Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840 At this Emergency Preparedness survey, The Waters of Dillsboro-Ross Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 123 certified beds. At the time of the survey, the census was 68. Quality Review completed on 04/07/25	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. 02	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(s): 04/01/25 & 04/02/25 Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840 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 with state	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki McGuire	Administrator	05/01/2025

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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	Dillsboro-Ross Manor 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, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro, Building 02, is a two story facility with a basement and was determined to be of Type V (000) construction and fully sprinklered. Ross Manor, Building 03, is a one story facility and was determined to be Type V (111) construction and fully sprinklered. Both facilities have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms in the Waters of Dillsboro building and the Ross Manor building. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 04/07/25		and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
K 0161 SS=F Bldg. 02	NFPA 101 Building Construction Type and Height 1. Based on observation and interview, the facility failed to ensure 1 of 2 floors was constructed with a 1 hour rated floor structure. The minimum building construction classification allowed for a two story building is Type V (111) requiring the	K 0161	The facility has conducted an FSES that demonstrates equivalent safety to that of NFPA 101, Life Safety Code and has achieved a passing score.	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	floor/ceiling assembly between the floors to have a one hour fire resistive rating. This deficient practice affects all residents who reside in the Waters of Dillsboro building. Findings include: Based on observations with the Maintenance Director at 12:40 p.m. on 04/02/25, the basement was separated from the first floor with exposed wood floor joists in the east basement storage room, the southwest basement boiler room and the northwest basement maintenance workshop room which classifies the construction type of the building as Type V (000). Based on interview at 12:40 p.m. on 04/02/25, the Maintenance Director stated the first floor is constructed of one half inch plywood with vinyl flooring throughout the first floor with no fire rated material. The basement ceiling lacking one hour construction was confirmed by the Maintenance Director at the time of observations. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to provide documentation of the fire resistance rating of the second floor ceiling smoke barrier construction to ensure the attic has the required number of smoke barrier walls extending to the underside of the roof. LSC Section 19.3.7.3 states any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following:			

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	155280	A. BUILDING 02 B. WING	04/02/2025

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	(1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2) *Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. Section 8.5.2.1 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. Section 8.5.2.2 states smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Section 8.5.2.3 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. Section 8.3.1.2* Fire barriers shall comply with one of the following: (1) The fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. (2) The fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, and from the floor to the bottom of the interstitial space, provided that the construction assembly forming the bottom of the interstitial			

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	space has a fire resistance rating not less than that of the fire barrier. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director at 10:00 a.m. on 04/01/25, facility blueprint documentation was not available for review. Documentation of the fire resistance rating of the second floor ceiling smoke barrier was also not available for review. Based on observations with the Maintenance Assistant at 12:40 p.m. on 04/02/25, the exact location of smoke barrier and fire barrier walls could not be determined. The attic was fully sprinklered and was not used for storage but contained no smoke or fire barrier walls extending to the underside of the roof deck above. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)			
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 3 of 14 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20	K 0222	It is the intent of the facility to ensure the means of egress through exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the	04/23/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Assistant at 10:54 a.m. on 04/02/25, the exit door set by resident sleeping Room 64 was marked as a facility exit with an exit sign. The door set could be opened by entering a four digit code at a keypad by the exit door set but the code to open the door set was not posted. Based on interview at 10:54 a.m. on 04/02/25, the Maintenance Assistance agreed the code to open the door set was not posted at the keypad. Based on observations with the Maintenance Assistant at 11:36 a.m. on 04/02/25, the exit door set leading to the outside of the facility in the first floor Therapy Room was marked as a facility exit with an exit sign. The door set could be opened by entering a four digit code at a keypad by the exit door set but an incorrect code to open the door set was posted. The posted code stated "2 month/2 year *" but entering that code did not release the door set to open. The Maintenance Assistant tried multiple variations of the posted code, but the door set did not release to open. Based on interview at 11:36 a.m. on 04/02/25, the Maintenance Assistance agreed that the correct code to open the door set was not posted at the keypad. Based on observations with the Maintenance Director at 12:10 p.m. on 04/02/25, the exit door leading to the second floor stairwell by resident sleeping Room 37 was marked as a facility exit with an exit sign. The door could be opened by entering a four digit code at a keypad by the exit door but the code to open the door was not posted. Based on interview at 12:10 p.m. on 04/02/25, the Maintenance Director agreed the code to open the door was not posted at the		Maintenance Supervisor/designee posted instructions on how to obtain the code at the exit door set by resident room 64 and first floor therapy room to meet set standards. The Administrator verified the work on 4/16/2025. 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. On 4/15/2025 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designee and all staff to ensure means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures including information posted on how to obtain the codes to meet set standards. b Maintenance Supervisor/designee will ensure means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures including information posted on how to obtain the codes as a part of the facility's weekly Preventive Maintenance Program and	

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	keypad. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		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 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 4/23/2025.**	
K 0225 SS=E Bldg. 02	NFPA 101 Stairways and Smokeproof Enclosures			

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	Based on observation and interview, the facility failed to ensure 1 of 2 exterior stairs comply with the requirements of 7.2.2.3.3.1. Section 7.2.2.3.3.1 states: Stair treads and landings shall be solid, without perforations. Section 7.2.2.3.3.2 states: Stair treads and landings shall be free of projections or lips that could trip stair users. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Assistant at 11:27 a.m. on 04/02/25, the facility exit by the elevator by the exit door by Room 7 was marked as a facility exit with an exit sign. The exterior stairs for this facility exit was metal construction without solid risers and treads. The stairs consisted of one landing and eight stairs. Based on interview at 11:27 a.m. on 04/02/25, the Maintenance Assistant agreed the aforementioned stairs were without solid risers and treads. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)	K 0225	The facility has conducted an FSES that demonstrates equivalent safety to that of NFPA 101, Life Safety Code and has achieved a passing score.	04/24/2025
K 0291 SS=E Bldg. 02	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 9 battery powered emergency lighting systems were maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly	K 0291	It is the intent of the facility to ensure battery powered emergency lighting systems are maintained in accordance with LSC Section 7.9 to meet set standards. **1.CORRECTIVE ACTIONS**	04/23/2025

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	charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant at 12:04 p.m. on 04/02/25, the battery powered emergency lighting system installed in the enclosed stairwell outside of the building failed to illuminate when its respective test button was pushed multiple times. The enclosed outside stairwell is in the exit discharge for the second floor exit by resident sleeping Room 55. Based on interview at 12:04 p.m. on 04/02/25, the Maintenance Assistant agreed the aforementioned battery powered emergency light failed to illuminate when its test button was pushed multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		**TAKEN**: 1.On 4/15/2025 the Maintenance Supervisor/designee repaired the battery powered emergency lighting system installed in the enclosed stairwell outside of the building to ensure it illuminates when tested for the second floor exit by resident sleeping room 55 to meet set standards. The Administrator verified the work on 4/16/2025. **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 4/17/20258 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to maintain battery powered emergency lighting systems are maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure to maintain battery powered emergency lighting systems are maintained as a part of the facility's monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee	

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			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 4/23/2025.**	
K 0311 SS=E Bldg. 02	NFPA 101 Vertical Openings - Enclosure 1. Based on observation and interview, the facility failed to maintain protection of 2 of 4 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that	K 0311	The facility has conducted an FSES that demonstrates equivalent safety to that of NFPA 101, Life Safety Code and has achieved a passing score.	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Fire doors assemblies are in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, Section 4.8.4.1 states the clearance under the bottom of a door shall be a maximum of 3/4th's inch. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director at 12:47 p.m. on 04/02/25, the stairwell door on the first floor by Room 7 and on the second floor by Room 37 were each not equipped with a fire resistance rating label. Based on interview at 12:47 p.m. on 04/02/25, the Maintenance Director agreed the stairwell doors were not equipped with fire resistance rating labels. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the protection of the soiled linen chutes and the two-story convenience stairs was in accordance of 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or			

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	8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director at 12:10 p.m. on 04/02/25, the soiled linen chute in the electrical room by Room 39 on the second floor and on the first floor by Room 5 contains wood as part of the construction of the shaft. In addition, based on observations with the Maintenance Director at 12:47 p.m. on 04/02/25, the stairwell wall on the first story by Room 20 and on the second floor by Room 26 only extends to the underside of the suspended acoustical tile ceiling system. Removing the tile in the ceiling system exposes the wood top plate and edge of the gypsum board wall assembly. The existing two-story convenience stair opening does not appear to be enclosed by a minimum one-hour fire-rated construction. Based on interview at 12:47 p.m. on 04/02/25, the Maintenance Director agreed the soiled linen chute and the two story convenience stairs did not appear to be complete with fire-rated assemblies. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0324 SS=D Bldg. 02	NFPA 101 Cooking Facilities Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems were inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all kitchen staff. Findings include:	K 0324	It is the intent of the facility to ensure kitchen exhaust systems are inspected semiannually to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 4/22/2025 the facility's licensed kitchen hood inspector is scheduled to conduct the kitchen exhaust system inspection; results will be documented in the facility's Life Safety Binder to meet set standards. The Administrator will verify the work on 4/23/2025. **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 4/17/2025 the Administrator in serviced the Maintenance Supervisor/Dietary Manager and all dietary staff to ensure the kitchen exhaust system is properly inspected semiannually to meet set standards. b. The Maintenance Supervisor and Dietary Manager will ensure the kitchen exhaust system is properly inspected semiannually as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	04/02/2025

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	Based on record review with the Maintenance Director at 1:10 p.m. on 04/01/25, documentation of kitchen exhaust system inspections within the most recent twelve month period was not available for review. Based on interview at 1:10 p.m. on 04/01/25, the Maintenance Director stated an inspection contractor performed semi-annual kitchen exhaust system inspections within the most recent twelve month period but agreed the documentation for the inspections was not available for review. Based on observations with the Maintenance Assistant at 11:14 a.m. on 04/02/25, the kitchen range hood inspection contractor had affixed a sticker to the range hood in the kitchen indicating the most recent kitchen exhaust inspection was conducted in December 2024. No other semi-annual range hood inspection documentation was affixed to the kitchen range hood. Based on interview at 11:14 a.m. on 04/02/25, the Maintenance Assistant agreed documentation of kitchen exhaust system inspection six months prior to December 2024 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		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 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 4/24/2025.**	
K 0325 SS=E Bldg. 02	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) 1. Based on observation and interview, the failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) installed in the corridor were installed where the corridor is at least 6 feet wide. This	K 0325	It is the intent of the facility to ensure alcohol-based hand sanitizer installed in the corridor are installed where the corridor is	04/23/2025

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	deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant at 11:43 a.m. on 04/02/25, an alcohol based hand sanitizer dispenser was installed on the corridor wall outside resident sleeping Room 9. The corridor outside resident sleeping Room 9 was less than six feet wide. Manufacturer's documentation affixed to the sanitizer solution inside the dispenser indicated it was 80% ethyl alcohol by volume. Based on interview at 11:43 a.m. on 04/02/25, the Maintenance Assistant agreed an alcohol based hand sanitizer was installed in the corridor outside resident sleeping Room 9 where the corridor was less than six feet wide. Based on observations with the Maintenance Director at 12:13 p.m. on 04/02/25, an alcohol based hand sanitizer dispenser was installed on the corridor wall outside resident sleeping Room 28. The corridor outside resident sleeping Room 28 was less than six feet wide. Manufacturer's documentation affixed to the sanitizer solution inside the dispenser indicated it was 80% ethyl alcohol by volume. Based on interview at 12:13 p.m. on 04/02/25, the Maintenance Director agreed an alcohol based hand sanitizer was installed in the corridor outside resident sleeping Room 28 and stated the corridor width outside Room 28 was five and a half feet wide. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		at least 6 feet wide and to ensure alcohol based hand sanitizers are not installed over an ignition source in resident sleeping rooms to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the Maintenance Supervisor/designee relocated the alcohol-based hand sanitizer dispenser to be at least 6 feet from the corridor to resident sleeping room 9 & room 28 to meet set standards. The Administrator verified the work on 4/16/2025. b On 4/15/2025 the Maintenance Supervisor/designee relocated the alcohol-based hand sanitizer dispenser to not be over an electric outlet/ ignition source inside resident sleeping room 2 to meet set standards. The Administrator verified the work on 4/16/2025. **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. On 4/15/2025 the Maintenance Supervisor/designee inspected the location of all alcohol-based hand sanitizer dispensers and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designee	

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	155280	A. BUILDING 02 B. WING	04/02/2025

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	2. Based on observation and interview, the facility failed to ensure alcohol based hand sanitizers were not installed over an ignition source in 1 of over 50 resident sleeping rooms. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect two residents, staff and visitors in resident sleeping Room 2. Findings include: Based on observations with the Maintenance Assistant at 11:21 a.m. on 04/02/25, an alcohol based hand sanitizer dispenser was installed on the wall inside resident sleeping Room 2 directly above a wall mounted electrical receptacle outlet box near the corridor door to the room. Manufacturer's documentation affixed to the sanitizer solution inside the dispenser indicated it was 80% ethyl alcohol by volume. Based on interview at 11:21 a.m. on 04/02/25, the Maintenance Assistant agreed an alcohol based hand sanitizer was installed in resident sleeping Room 2 on the wall directly above a wall mounted outlet box in the room. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		on the requirement that alcohol-based hand sanitizers cannot be installed where the corridor is at least 6 feet wide and not over an ignition source to meet set standards. b Maintenance Supervisor/designee will inspect all alcohol-based hand sanitizers throughout the facility monthly to ensure they are in the proper locations 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 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	

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			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 4/23/2025.**	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors in the Waters of Dillsboro building. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility at 9:50 a.m. on 04/01/25, the main fire alarm control panel in the corridor near the entrance to the Lenover Street dining area on the first floor of the Waters of Dillsboro building was in the trouble mode and was silenced. Based on interview at 9:50 a.m. on 04/01/25, the Maintenance Director stated a pull station which a resident had damaged needed repair, the facility had a service call in to the fire alarm system	K 0345	– It is the intent of the facility to ensure fire alarm systems are maintained in accordance with LSC 9.6.1.3 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/16/2025 the facility's licensed fire alarm contractor/maintenance supervisor/designee made repairs to the pull station to meet set standards. The Administrator verified the work on 4/16/2025. 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 4/17/2025 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure	04/23/2025

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	inspection contractor for the repair and stated the fire alarm system is operable and would function if necessary. Based on observations with the Maintenance Director at 11:00 a.m. on 04/02/25, the main fire alarm control panel was still in the trouble mode and was silenced. Based on interview at 11:00 a.m. on 04/02/25, the Maintenance Director stated the fire alarm system has additional system defects which the fire alarm system contractor is still looking into. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		proper maintenance of the fire alarm system to meet set standards. b Maintenance Supervisor/Licensed Fire Alarm Contractor/designee will ensure proper maintenance of the fire alarm system 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 be presented by the Maintenance Supervisor/designee to the Administrator 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.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/23/2025.	
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the smoke barrier door by the vending machines on the first floor near the employee break room. Findings include: Based on observations with the Maintenance Assistant at 11:06 a.m. on 04/02/25, the single leaf smoke barrier door by the vending machines on the first floor near the employee break room failed to fully self close when tested to close multiple times. The bottom of the door kept hitting the floor when swinging to close and became stuck on the floor before it could fully self close. The door was held in the fully open position with a wall mounted magnetic hold open device set to release with fire alarm system activation and was equipped with a self closing device. Based on interview at 11:06 a.m. on 04/02/25, the Maintenance Assistant agreed the	K 0374	It is the intent of the facility to ensure smoke barrier doors would restrict the movement of smoke for at least 20 minutes to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the Maintenance Supervisor/designee repaired the single leaf smoke barrier doors by the vending machines on the first floor near the employee break room to ensure it self closes and latches into the frame to meet set standards. The Administrator verified the repairs on 4/16/2025. 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. On 4/15/2025 the Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**:	04/23/2025

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	aforementioned smoke barrier door failed to fully self close leaving a large gap which would not resist the movement of smoke for at least 20 minutes. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		a On 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designee and all staff the requirement that smoke barrier doors must close completely to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure they close completely and have no impediments to closing 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 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	

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			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 4/23/2025.**	
K 0541 SS=E Bldg. 02	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Based on observation and interview, the facility failed to maintain 1 of 1 laundry chutes in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment. LSC 9.5.2 requires laundry chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 and Section 5.2.3.3.2.1 requires all chute loading doors shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 20 residents, staff and visitors on the second floor. Findings include: Based on observations with the Maintenance Director at 12:20 p.m. on 04/02/25, the door to the soiled linen chute in the electrical room by Room 39 on the second floor was equipped with a self closing device but the chute door was observed in the fully open position and would not self close when tested to close multiple times. It appeared the self closing device was stuck or no longer operable. Based on interview at 12:20 p.m. on 04/02/25, the Maintenance Director agreed the	K 0541	– It is the intent of the facility to ensure to maintain laundry chutes in accordance with NFPA 82 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the Maintenance Supervisor/designee repaired the door to soiled linen chute in the electrical room by Room 39 on the second floor to ensure it latches into frame when self-closing to meet set standards. The Administrator verified the work on 4/16/2025. 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 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement	04/23/2025

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	155280	A. BUILDING 02 B. WING	04/02/2025

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	soiled linen chute door failed to self close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		that self-closing hardware must have properly working latches to ensure closure to meet set standards. b Maintenance Supervisor/designee will inspect all self-closing hardware throughout the facility monthly to ensure they close properly 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 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	

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	155280	A. BUILDING 02 B. WING	04/02/2025

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/23/2025.**	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. on the first shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director at 1:30 p.m. on 04/01/25, documentation for the first shift fire drill conducted on 07/24/24 during the third quarter (July, August, September) 2024 indicated the drill was a first shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. and did not document activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned first shift fire drill documentation stated "Yes" in response to "Silent Alarm". Section 1.g of the 07/24/24 "Fire Drill Report" documentation was	K 0712	It is the intent of the facility to ensure to document activation of the fire alarm system on fire drills conducted between 6:00 am and 9:00 pm on the first shift for all 4 quarters to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/17/2025 the Administrator inserviced Maintenance Supervisor on the proper fire drill procedures and conducted fire training for all staff members to meet set standards. 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 4/17/2025 the Administrator inserviced the Maintenance Supervisor/all staff on the requirement to ensure all staff are familiar with and understand the fire drill policy and procedures to meet set standards. b Maintenance	04/23/2025

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	155280	A. BUILDING 02 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	left blank in regard to "Transmission of alarm to monitoring company/Fire Dept?". The 07/24/24 first shift fire drill documentation also stated the drill was conducted at 1:15 a.m. Based on interview at 1:30 p.m. on 04/01/25, the Maintenance Director stated the 07/24/24 fire drill was a first shift fire drill conducted at 1:15 p.m. not 1:15 a.m., the facility operates three shifts per day and agreed the 07/24/24 first shift fire drill conducted at 1:15 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b) 3.1-51(c)		Supervisor/Administrator/designee will ensure all staff are familiar with and understand the fire drill policy and procedures 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 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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			Our date of compliance is 4/23/2025.	
K 0914 SS=F Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was completed in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents, staff and visitors. Findings include: Based on review of "Monthly Receptacle Inspections" documentation for the most recent	K 0914	It is the intent of the facility to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms is completed in accordance with NFPA 99 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the Maintenance Supervisor completed the annual resident room receptacle testing including documenting the results of inspection and testing for the continuity of the grounding circuit, the correct polarity and also the retention force testing for each electrical receptacle and documented the results in the facility's Life Safety Binder to meet set standards. The Administrator verified the work 4/16/2025. 2 **ALL OTHERS WITH POTENTAL 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 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designee on the requirement the annual	04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	twelve month period with the Maintenance Director at 1:06 p.m. on 04/01/25, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was incomplete. The monthly inspection documentation indicated it was a "visual inspection to ensure receptacles are secured and no defects" but did not list the results of inspection and testing for the continuity of the grounding circuit, the correct polarity and also did not list retention force testing for each electrical receptacle tested. Based on interview at 1:06 p.m. on 04/01/25, the Maintenance Director stated additional receptacle testing documentation for the most recent twelve month period was not available for review, each resident sleeping room may have a mix of hospital grade and non-hospital grade receptacles installed in the room and agreed monthly electrical receptacle testing documentation did not list the results of inspection and testing for the continuity of the grounding circuit, the correct polarity and also did not list retention force testing for each electrical receptacle tested. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		electrical receptacle testing must be completed annually and documented in the life safety binder to meet set standards. b Maintenance Supervisor/designee will ensure the annual electrical receptacle testing is completed 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 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/23/2025.**	
K 0920 SS=D Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure non-fused multiplug adapters were not used as a substitute for fixed wiring in 1 of over 60 resident sleeping rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect 2 residents, staff and visitors in the resident sleeping Room 63. Findings include: Based on observations with the Maintenance Assistant at 10:55 a.m. on 04/02/25, a telephone, a cell phone charging cable and an electric powered reclining chair were plugged into a multiplug adaptor plugged into a receptacle in the wall mounted outlet box near the resident bed nearest the corridor door in resident sleeping Room 63.	K 0920	It is the intent of the facility to ensure non fused multiplug adapters were not used as a substitute for fixed wiring in resident sleeping rooms to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 4/15/2025 the Maintenance Supervisor/designee removed the multiplug adaptor in resident room 63 to meet set standards. The Administrator verified the removal on 4/16/2025. **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. On 4/15/2025 the Maintenance Supervisor/designee inspected all rooms throughout the facility for multiplug adaptors and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 4/17/2025 the	04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Based on interview at 10:55 a.m. on 04/02/25, the Maintenance Assistant agreed a multiplug adaptor was being used as a substitute for fixed wiring in resident sleeping Room 63. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		Administrator inserviced the Maintenance Supervisor/designee/all other staff that multiplug adaptors are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have multiplug adaptors in use 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. 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	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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 4/23/2025.**	
K 0921 SS=F Bldg. 02	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 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 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	K 0921	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 4/14/2025 and 4/15/2025 the facility's trained Regional Property Managers will conduct PCREE testing on the other PCREE in the facility including: electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator verified the work on 4/16/2025. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to	04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	04/02/2025

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	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 in the Waters of Dillsboro. Findings include: Based on record review with the Maintenance Director at 1:30 p.m. on 04/01, PCREE testing documentation was not available for review. Based on interview at 1:30 p.m. on 04/01/25, the Maintenance Supervisor agreed PCREE testing documentation was not available for review. Review of "Bed Systems Compliance Audit" documentation dated January 2025 with the Maintenance Director at 1:30 p.m. on 04/01/25 indicated visual inspections were conducted for electric beds in each resident sleeping room. Based on observations with the Maintenance Director at 11:21 a.m. on 04/02/25, an oxygen concentrator was in use in resident sleeping Room 2. Based on observations with the Maintenance Director at 12:00 p.m. on 04/02/25, an oxygen concentrator was also in use in resident sleeping Room 48. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 4/17/2025 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 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.	

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			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 4/23/2025.**	
K 0000 Bldg. 03	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(s): 04/01/25 & 04/02/25 Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840 At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor 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, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro,	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. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	

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	155280	A. BUILDING 03 B. WING	04/02/2025

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	Building 02, is a two story facility with a basement and was determined to be of Type V (000) construction and fully sprinklered. Ross Manor, Building 03, is a one story facility and was determined to be Type V (111) construction and fully sprinklered. Both facilities have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms in the Waters of Dillsboro building and the Ross Manor building. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 04/07/25			
K 0363 SS=E Bldg. 03	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 25 corridor doors to resident sleeping rooms in Ross Manor would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 10 in Ross Manor. Findings include: Based on observations with the Maintenance Director at 2:25 p.m. on 04/01/25, a 3/4th's inch gap was noted in between the face of the corridor door and the door stop on the door frame to resident sleeping Room 10 in Ross Manor when the door	K 0363	It is the intent of the facility to ensure corridor doors to resident sleeping rooms in Ross Manor would resist the passage of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 4/15/2025 the Maintenance Supervisor/designee repaired Resident room 10 door/door frame to meet set standards. The Administrator verified the repair on 4/16/2025. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 03 B. WING	04/02/2025

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WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	was in the fully closed and latched position. A notch had been cut out of the latching plate on the door frame which caused the latching mechanism on the door frame to protrude into its opening on the door frame but not into its intended more restrictive opening for the latching plate which caused a gap of greater than 1/4th's inch for a sprinklered building. Based on interview at 2:25 p.m. on 04/01/25, the Maintenance Director agreed a notch had been cut out of the latching plate on the door frame which caused a gap in between the face of the corridor door to resident sleeping Room 10 and the door stop on the door frame which would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference on 04/02/25. 3.1-19(b)		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 4/17/2025 the Administrator in serviced the Maintenance Supervisor/All staff on the requirement to ensure corridor doors close, latch into the door frame and ensure there are no gaps to meet set standards. b Maintenance Supervisor/designee will ensure corridor doors close, latch into the door frame and ensure there are no gaps 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	

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	155280	A. BUILDING 03 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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 4/23/2025.**	