OLITERO I OI	THE PROPERTY OF THE PARTY OF TH	THE SERVICES			512 51 0700 007	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155280	B. WING		04/02/2025	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2		LENOVER ST		
WATERS	OF DILLSBORO-F	ROSS MANOR, THE	DILLS			
(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 CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
5						
Bldg						
		paredness Survey was	E 0000	DISCLAIMER STATEMENT:		
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date(s): 04/01/25 & 04/02/25			Preparation and/or execution		
				this plan of correction in gener		
				or this corrective action, does	not	
				constitute an admission or		
	Facility Number: 0	00178		agreement by this facility of the facts alleged or conclusions se		
	Provider Number:			forth in this statement of	5ι   	
	AIM Number: 100			deficiencies. The plan of		
	100			correction and specific correct	ive	
	At this Emergency Preparedness survey, The			actions are prepared and/or		
		o-Ross Manor was found in		executed in compliance with s	tate	
	compliance with Emergency Preparedness			and federal laws. This plan of		
	_	Medicare and Medicaid		correction constitutes a writter		
	_	ders and Suppliers, 42 CFR		allegation of substantial		
	483.73.			compliance with Federal Medi	care	
				and Medicaid requirements.		
	The facility has 123	3 certified beds. At the time of				
	the survey, the cens	sus was 68.				
	Quality Review cor	mpleted on 04/07/25				
K 0000						
DIda 00						
Bldg. 02	A I :fo C-f-t- C 1	Decentification or 1 State	17,0000	DICCLAIMED CTATEMENT		
		Recertification and State vas conducted by the Indiana	K 0000	DISCLAIMER STATEMENT:	of .	
	•	•		Preparation and/or execution of		
	483.90(a).	Ith in accordance with 42 CFR		this plan of correction in gener or this corrective action, does		
	703.70(a).			constitute an admission or	IIOt	
	Survey Date(s): 04/	01/25 & 04/02/25		agreement by this facility of the	_	
				facts alleged or conclusions se		
	Facility Number: 0	000178		forth in this statement of	-	
	Provider Number:			deficiencies. The plan of		
	AIM Number: 100			correction and specific correct	ive	
				actions are prepared and/or		
	At this Life Safety	Code survey, The Waters of		executed in compliance with s	tate	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Vicki McGuire Administrator 05/01/2025

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TOHY21 Facility ID: 000178 If continuation sheet Page 1 of 34

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPL	
		155280	B. W	ING		04/02	/2025
NAME OF E	PROVIDER OR SUPPLIEF	)	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSB	3ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	E COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
		nor was found not in			and federal laws. This plan of		
	1 -	equirements for Participation in			correction constitutes a writter	1	
		l, 42 CFR Subpart 483.90(a), re and the 2012 edition of the			allegation of substantial		
	· ·	ction Association (NFPA) 101,			compliance with Federal Medicare and Medicaid requirements.		
	Life Safety Code, Chapter 19, Existing Health Care				and Medicald requirements.		
	Occupancies and 41						
		sboro-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						
	_	ype V (111) construction and					
	·	Both facilities have a fire alarm					
		detection on all levels of the					
	1 -	building and Ross Manor					
		the corridors, spaces open to					
		as battery operated smoke					
		dent sleeping rooms in the					
		building and the Ross Manor					
		ers of Dillsboro-Ross Manor					
	_	23 and had a census of 68 at					
	the time of this visi						
	A 11 1						
		idents have customary access					
	_	all areas providing facility					
	services were sprin	Kiereu.					
	Quality Review cor	mpleted on 04/07/25					
K 0161	NFPA 101						
SS=F Bldg. 02		tion Type and Height					
J	1. Based on observa	ation and interview, the facility	ΚO	161	The facility has conducted an		04/24/2025
		f 2 floors was constructed with	110		FSES that demonstrates		0 1.2 1.2025
		structure. The minimum			equivalent safety to that of NF	PA	
		on classification allowed for a			101, Life Safety Code and has		
		is Type V (111) requiring the			achieved a passing score.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 2 of 34

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPL	
		155280	B. W	ING		04/02/	/2025
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	-	12803 L	NDDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI ANI OF CODDECTION		(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		TAG	DEFICIENCY)		DATE
	_	oly between the floors to have					
		stive rating. This deficient					
	1 ~	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						
	_	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						
		es the construction type of the					
		(000). Based on interview at					
	_	2/25, the Maintenance Director is constructed of one half					
		vinyl flooring throughout the					
		ire rated material. The					
		cking one hour construction					
		he Maintenance Director at the					
	time of observation						
	These findings were	e reviewed with the					
	1	he Maintenance Director					
		Gerence on 04/02/25.					
	3.1-19(b)						
	2. Based on record	review, observation and					
	interview; the facili	ty failed to provide					
		ne fire resistance rating of the					
	_	smoke barrier construction to					
		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						
		d shall have a minimum					
		nce rating, unless otherwise					
	permitted by one of	_					
	1 1		1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 3 of 34

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280		A. BUILDING B. WING	02 	COMPL 04/02/	ETED	
NAME OF P	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP COD LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		3ORO, IN 47018		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	ON DE	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE
IAG		at shall not apply where an	IAG			DATE
		both of the following criteria				
	also shall apply:	5				
		shall be permitted to terminate				
	at an atrium wall co	instructed in accordance with				
	8.6.7(1)(c).					
	(b) Not less than tw	-				
		be provided on each floor.				
		s 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.					
		es smoke barriers required by				
		ontinuous from an outside				
	wall to an outside w	vall, from a floor to a floor, or				
	from a smoke barrie	er to a smoke barrier, or by use				
		ereof. Section 8.5.2.2 states				
		l be continuous through all				
	_	uch as those found above a				
		nterstitial spaces. Section				
		e barriers required by this Code from an outside wall to an				
		floor to a floor, or from a				
		moke barrier, or by use of a				
		f. Section 8.3.1.2* Fire barriers				
	shall comply with o					
		are continuous from outside				
	wall to outside wall	or from one fire barrier to				
	· ·	nation thereof, including				
		all concealed spaces, such as				
		ceiling, including interstitial				
	spaces.					
	` '	are continuous from outside				
		or from one fire barrier to				
	· ·	ne floor to the bottom of the				
		ovided that the construction				
	assembly forming th	he bottom of the interstitial				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

If continuation sheet

Page 4 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 I	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	space has a fire resi that of the fire barri This deficient pract Findings include:  Based on record rev Director at 10:00 a. documentation was Documentation of t second floor ceiling available for review the Maintenance As 04/02/25, the exact fire barrier walls co attic was fully sprin storage but contains walls extending to t above.	riew with the Maintenance m. on 04/01/25, facility blueprint not available for review. he fire resistance rating of the smoke barrier was also not r. Based on observations with sistant at 12:40 p.m. on location of smoke barrier and uld not be determined. The klered and was not used for ed no smoke or fire barrier he underside of the roof deck	TAG	DEFICIENCY)	DATE
K 0222 SS=E	3.1-19(b)  NFPA 101  Egress Doors				
Bldg. 02	Based on observation failed to ensure the 14 exits were readil without a clinical dissecurity measures. of egress shall not be lock that requires the egress side unless of Section 19.2.2.2.4. shall be permitted in	on and interview, the facility means of egress through 3 of y accessible for residents agnosis requiring specialized Doors within a required means be equipped with a latch or use use of a tool or key from the therwise permitted by LSC Door-locking arrangements in accordance with 19.2.2.2.5.2. ice 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 resident without a clinical diagnosis requiring specialized security measures to meet set standards.  1 CORRECTIVE ACTIONS TAKEN: a On 4/15/2025 the	t

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet

Page 5 of 34

ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	LETED
		155280	B. W	ING		04/02	/2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LENOVER ST		
\\/\TED		ROSS MANOR, THE			BORO, IN 47018		
WATER	OF DILLOBORO-	NOSS WANON, THE		DILLOL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	residents, staff and	visitors if needing to exit the			Maintenance Supervisor/desig	gnee	
	facility.				posted instructions on how to		
					obtain the code at the exit dod	or	
	Findings include:				set by resident room 64 and fi	irst	
					floor therapy room to meet se	t	
	Based on observati	ons with the Maintenance			standards. The Administrator		
	Assistant at 10:54 a.m. on 04/02/25, the exit door				verified the work on 4/16/2025	5.	
	set by resident sleeping Room 64 was marked as a				2 ALL OTHERS WITH		
	facility exit with ar	exit sign. The door set could			POTENTIAL TO BE AFFECTI	ED:	
	be opened by enter	ing a four digit code at a			a All residents and all staf	f	
	keypad by the exit	door set but the code to open			and visitors have the potential	l to	
	the door set was not posted. Based on interview				be affected but none were. O	n	
	at 10:54 a.m. on 04	/02/25, the Maintenance			4/15/2025 the Maintenance		
	Assistance agreed t	the code to open the door set			Supervisor/designee inspecte	d all	
	was not posted at the	ne keypad. Based on			doors and found no other neg	ative	
	observations with t	he Maintenance Assistant at			findings.		
	11:36 a.m. on 04/0	2/25, the exit door set leading to			3 MEASURES TO PREVE	NT	
	the outside of the fa	acility in the first floor Therapy			REOCCURRENCE:		
		as a facility exit with an exit			a On 4/17/2025 the		
	sign. The door set	could be opened by entering a			Administrator inserviced the		
	four digit code at a	keypad by the exit door set but			Maintenance Supervisor/design	gnee	
	an incorrect code to	o open the door set was			and all staff to ensure means	of	
	posted. The posted	l code stated "2 month/2 year			egress through exit doors are		
	*" but entering that	code did not release the door			readily accessible for resident	ts	
	set to open. The M	laintenance Assistant tried			without a clinical diagnosis		
	multiple variations	of the posted code, but the			requiring specialized security		
	door set did not rel	ease to open. Based on			measures including information	on	
	interview at 11:36	a.m. on 04/02/25, the			posted on how to obtain the c	odes	
	Maintenance Assis	tance agreed that the correct			to meet set standards.		
	code to open the do	oor set was not posted at the			b Maintenance		
	keypad. Based on	observations with the			Supervisor/designee will ensu	ıre	
	Maintenance Direc	tor at 12:10 p.m. on 04/02/25,			means of egress through exit		
	the exit door leading	g to the second floor stairwell			doors are readily accessible for	or	
	by resident sleeping	g Room 37 was marked as a			residents without a clinical		
	facility exit with ar	exit sign. The door could be			diagnosis requiring specialize	d	
	opened by entering	a four digit code at a keypad			security measures including		
	by the exit door bu	t the code to open the door			information posted on how to		
	was not posted. Ba	ased on interview at 12:10 p.m.			obtain the codes as a part of t	the	
	on 04/02/25, the M	aintenance Director agreed the			facility's weekly Preventive		

FORM CMS-2567(02-99) Previous Versions Obsolete

code to open the door was not posted at the

Event ID:

TOHY21

Facility ID: 000178

Maintenance Program and

If continuation sheet

Page 6 of 34

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIED S OF DILLSBORO-	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018		
(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)	(X5) COMPLETION DATE	
K 0225	Administrator and	e reviewed with the the Maintenance Director ference on 04/02/25.		document those inspection resas appropriate. If any issues discovered, they will be addresand resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results.  The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  MONITORING CORRECTIVE ACTION:  The inspection results where be presented by the Maintenance supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance 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 4/23/2025.	are ssed e inee tor	
SS=E Bldg. 02		nokeproof Enclosures				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet

Page 7 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPL	
		155280	B. W	ING		04/02/	/2025
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSE	3ORO, IN 47018		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		on and interview, the facility	K 0	TAG	The facility has conducted an		04/24/2025
		f 2 exterior stairs comply with	I K U	223	FSES that demonstrates		04/24/2023
	the requirements of 7.2.2.3.3.1. Section 7.2.2.3.3.1				equivalent safety to that of NF	PA	
	-	and landings shall be solid,			101, Life Safety Code and has		
	without perforations. Section 7.2.2.3.3.2 states: Stair treads and landings shall be free of				achieved a passing score.		
		hat could trip stair users. This					
	_	ould affect over 20 residents,					
	staff and visitors if needing to exit the facility.						
	Findings include:						
	Based on observation	ons with the Maintenance					
	Assistant at 11:27 a.m. on 04/02/25, the facility exit						
	by the elevator by the	he exit door by Room 7 was					
		exit with an exit sign. The					
		is facility exit was metal					
		nt solid risers and treads. The					
		one landing and eight stairs. at 11:27 a.m. on 04/02/25, the					
	Maintenance Assist						
		irs were without solid risers					
	and treads.						
	These findings were						
		he Maintenance Director					
	during the exit conf	Ference on 04/02/25.					
	3.1-19(b)						
K 0291	NFPA 101						
SS=E	Emergency Lightin	ng					
Bldg. 02	-						
		on and interview, the facility	K 0	291	It is the intent of the facility to		04/23/2025
		f 9 battery powered emergency			ensure battery powered		
		ere maintained in accordance			emergency lighting systems a		
		9. LSC 7.9.2.6 states battery			maintained in accordance with	1	
		y lights shall use only reliable le batteries provided with			LSC Section 7.9 to meet set standards.		
		or maintaining them in properly			1.CORRECTIVE ACTIONS		
		S F	1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 8 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED.
		155280	B. WI	NG		04/02/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			LENOVER ST		
WATERS	S OF DILL SBORO-	ROSS MANOR, THE			BORO, IN 47018		
	· · · · · · · · · · · · · · · · · · ·	TOOS WINGTON, THE		DILLOL	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ~	Batteries used in such lights			TAKEN:		
		proved for their intended use			1.On 4/15/2025 the		
		rith NFPA 70, National Electric			Maintenance Supervisor/design	jnee	
		nt practice could affect over 10			repaired the battery powered		
	residents, staff and	visitors.			emergency lighting system		
					installed in the enclosed stairs		
	Findings include:				outside of the building to ensu		
					illuminates when tested for the	<del>)</del>	
		ons with the Maintenance			second floor exit by resident		
	Assistant at 12:04 p.m. on 04/02/25, the battery				sleeping room 55 to meet set		
	powered emergency lighting system installed in				standards. The Administrator		
	the enclosed stairwell outside of the building				verified the work on 4/16/2025	5.	
	failed to illuminate when its respective test button				2.ALL OTHERS WITH		
		e times. The enclosed outside			POTENTIAL TO BE AFFECTI		
		xit discharge for the second			1.All residents and all sta		
	· ·	nt sleeping Room 55. Based on			and visitors have the potential	to	
		o.m. on 04/02/25, the			be affected but none were.		
	Maintenance Assist	_			3.MEASURES TO PREVEN	Т	
		tery powered emergency light			REOCCURRENCE:		
		when its test button was			1.On 4/17/20258 the		
	pushed multiple tin	nes.			Administrator inserviced the		
					Maintenance Supervisor/design		
	_	e reviewed with the			on the requirement to ensure to		
		the Maintenance Director			maintain battery powered		
	during the exit conf	ference on 04/02/25.			emergency lighting systems a		
	2.1.10(1.)				maintained to meet set standa	ards.	
	3.1-19(b)				2.Maintenance	4	
					Supervisor/designee will ensu	re to	
					maintain battery powered		
					emergency lighting systems a	re	
					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 r		
					set standards. If any issues a		
					discovered, they will be addre		
					and resolved immediately. The		
	l		1		Maintenance Supervisor/design	inee	I .

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280		A. BUILDING  B. WING	02	COMPLETED 04/02/2025	
	ROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST SORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0311	NFPA 101			will review with the Administra 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 CORRECTI ACTION:  1. The inspection results to be presented by the Maintena Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performand 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 4/23/2025.	VE will nce nly ce .
SS=E Bldg. 02	Vertical Openings  1. Based on observa failed to maintain pr	tion and interview, the facility rotection of 2 of 4 interior 3.1 requires vertical openings	K 0311	The facility has conducted an FSES that demonstrates equivalent safety to that of NF	04/24/2025
	shall be enclosed or	protected in accordance with 6.1 requires every floor that		101, Life Safety Code and has achieved a passing score.	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	r í	JILDING	nstruction 02	(X3) DATE COMPL 04/02/	ETED
	PROVIDER OR SUPPLIER S OF DILLSBORO-F	ROSS MANOR, THE		12803 L	DDRESS, CITY, STATE, ZIP COD ENOVER ST ORO, IN 47018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	see 7.1.3.2.1 for end states the separation fire resistance rating stories or less. Fire accordance with NF Doors and Other Op Section 4.8.4.1 state bottom of a door shinch. This deficient residents, staff and Findings include:  Based on observation Director at 12:47 p. door on the first flo second floor by Rowith a fire resistance interview at 12:47 p. Maintenance Direct were not equipped valuels.  These findings were Administrator and the during the exit confidence of 19 to 19. Based on observation failed to ensure the chutes and the two-in accordance of 19 enclosure is provided not less than a 1-ho 8.3.4.2 states the fir protectives shall be	oke barrier. LSC 8.6.5 states closures of exits. LSC 7.1.3.2.1 a shall have a minimum 1-hr g where the exit connects three doors assemblies are in FPA 80, Standard for Fire bening Protectives. NFPA 80, as the clearance under the fall be a maximum of 3/4th's a practice could affect over 20 existors.  Ons with the Maintenance for by Room 7 and on the form 37 were each not equipped to rating label. Based on form. on 04/02/25, the or agreed the stairwell doors with fire resistance rating the energy of the maintenance of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

If continuation sheet

Page 11 of 34

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	, ,	JILDING	NSTRUCTION 02	(X3) DATE COMPL 04/02	ETED
	PROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	DDRESS, CITY, STATE, ZIP COD ENOVER ST ORO, IN 47018		
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	in vertical shafts, in 1-hour fire resistant existing fire door as 3/4-hour fire protectic continue to be used enclosures in lieu of protection rating redeficient practice costaff, and visitors.  Findings include:  Based on observation Director at 12:10 puchute in the electric second floor and or contains wood as pushaft. In addition, I Maintenance Director the stairwell wall of and on the second floor and or the underside of ceiling system. Responses the the gypsum board of two-story convenie appear to be enclose fire-rated construct 12:47 p.m. on 04/02 agreed the soiled linconvenience stairs with fire-rated asset.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

If continuation sheet

Page 12 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	02	COMPL	
		155280	B. WI	NG		04/02/	2025
	ROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST SORO, IN 47018		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
K 0324	NFPA 101						
SS=D	Cooking Facilities						
Bldg. 02	G						
-	Based on record rev	view, observation and	K 0	324	It is the intent of the facility to		04/24/2025
	interview; the facili	ty failed to ensure 1 of 1			ensure kitchen exhaust systen	ns	
	kitchen exhaust sys	tems were inspected			are inspected semiannually to		
	semiannually. NFP	A 96, 2011 Edition, Standard			meet set standards.		
		trol and Fire Protection of			1. CORRECTIVE ACTIONS		
	Commercial Cooking	ng Operations, Section 11.4			TAKEN:		
	states the entire exh	aust system shall be			a. On 4/22/2025 the facility's		
	inspected for grease	buildup by a properly			licensed kitchen hood inspecto		
	trained, qualified, a	nd certified person(s)			scheduled to conduct the kitch	nen	
	acceptable to the authority having jurisdiction				exhaust system inspection;		
	and in accordance with Table 11.4. Table 11.4,				results will be documented in t	the	
	Schedule for Inspec	tion for Grease Buildup,			facility's Life Safety Binder to		
	_	rving moderate volume			meet set standards. The		
	cooking operations	_			Administrator will verify the wo	ork	
		A 96, 11.6.1 states, upon			on 4/23/2025.		
	_	haust system is found to be			2. ALL OTHERS WITH		
	contaminated with	deposits from grease laden			POTENTIAL TO BE AFFECTE	ED:	
		nated portions of the exhaust			a. All residents and all staff ar	nd	
	system shall be clea	aned by a properly trained,			visitors have the potential to be	e	
	qualified, and certif	ied person(s) acceptable to the			affected but none were.		
	authority having jur	risdiction. Hoods, grease			3. MEASURES TO PREVENT		
	removal devices, fa	ns, ducts, and other			REOCCURRENCE:		
	appurtenances shall	be cleaned to remove			a. On 4/17/2025 the Administr	ator	
	combustible contan	ninants prior to surfaces			in serviced the Maintenance		
	becoming heavily c	ontaminated with grease or			Supervisor/Dietary Manager a	nd	
	oily sludge. After th	ne exhaust system is cleaned, it			all dietary staff to ensure the		
	shall not be coated	with powder or other			kitchen exhaust system is		
	substance. When an	exhaust cleaning service is			properly inspected semiannua	lly	
		nowing the name of the			to meet set standards.	ļ	
	servicing company,	the name of the person			b. The Maintenance Superviso	or	
		k, and the date of inspection or			and Dietary Manager will ensu	ıre	
	•	aintained on the premises.			the kitchen exhaust system is	ļ	
	This deficient pract	ice could affect all kitchen			properly inspected semiannua	lly	
	staff.				as a part of the facility's month	ıly	
					Preventive Maintenance Progr	ram	
	Findings include:				and document those inspectio	n	
					results as appropriate. If any		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/02/2025	
	ROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Based on record rev Director at 1:10 p.m of kitchen exhaust s most recent twelve	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION riew with the Maintenance a. on 04/01/25, documentation ystem inspections within the month period was not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  issues are discovered, they w addressed and resolved immediately. The Maintenanc Supervisor/designee will revie	DATE ill be
	p.m. on 04/01/25, the an inspection contraction contraction inspection contraction in the second contraction for the second contr	Based on interview at 1:10  me Maintenance Director stated actor performed semi-annual mem inspections within the month period but agreed the he inspections was not Based on observations with sistant at 11:14 a.m. on		with the Administrator the inspection results. c. The Administrator will mon adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation i place.	s in
	contractor had affix in the kitchen indica exhaust inspection versions where the contract of t	e reviewed with the the Maintenance Director		4. MONITORING CORRECTIVACTION:  a. The monitoring results will be presented by the Administrate the monthly Quality Assurance/Performance 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.	pe or at J. by
	3.1-19(b)	erence on 04/02/23.		This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 4/24/2025.	h
K 0325 SS=E Bldg. 02	Based on observa to ensure Alcohol B (ABHR) installed in	nd Rub Dispenser (ABHR)  Ition and interview, the failed lased Hand Rub Dispensers In the corridor were installed s at least 6 feet wide. This	K 0325	It is the intent of the facility to ensure alcohol-based hand sanitizer installed in the corrid are installed where the corrido	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>			COMPLETED	
		155280	B. W	ING		04/02	/2025	
				_				
NAME OF	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
				12803 LENOVER ST				
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSE	BORO, IN 47018			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
		ould affect over 20 residents,			at least 6 feet wide and to en	SUIFE		
	staff and visitors.	sala arreet ever 20 residents,			alcohol based hand sanitizers			
	stair and visitors.				not installed over an ignition	3 alc		
	Findings include:				source in resident sleeping ro	ome		
	i manigs metade.				to meet set standards.	001113		
	Based on observation	ons with the Maintenance			1 CORRECTIVE ACTION	e		
		.m. on 04/02/25, an alcohol			TAKEN:	3		
		r dispenser was installed on			a On 4/15/2025 the			
						anaa		
	the corridor wall outside resident sleeping Room  9. The corridor outside resident sleeping Room 9				Maintenance Supervisor/desi	-		
					relocated the alcohol-based h			
	was less than six feet wide. Manufacturer's				sanitizer dispenser to be at le			
	documentation affixed to the sanitizer solution inside the dispenser indicated it was 80% ethyl				feet from the corridor to resid			
	_				sleeping room 9 & room 28 to	)		
		Based on interview at 11:43			meet set standards. The	d		
		ne Maintenance Assistant			Administrator verified the wor	K ON		
		ased hand sanitizer was			4/16/2025.			
		idor outside resident sleeping corridor was less than six feet			b On 4/15/2025 the			
	wide. Based on obs				Maintenance Supervisor/desi	-		
					relocated the alcohol-based h			
		tor at 12:13 p.m. on 04/02/25, an			sanitizer dispenser to not be			
		sanitizer dispenser was			an electric outlet/ ignition sou			
		ridor wall outside resident			inside resident sleeping room	1 2 10		
	1	The corridor outside resident			meet set standards. The			
		was less than six feet wide.			Administrator verified the wor	'K on		
		umentation affixed to the			4/16/2025.			
		iside the dispenser indicated it			2 ALL OTHERS WITH			
	1	hol by volume. Based on			POTENTIAL TO BE AFFECT			
	_	o.m. on 04/02/25, the			a All residents and all sta			
		tor agreed an alcohol based			and visitors have the potentia			
		installed in the corridor outside			be affected but none were. C	On		
		oom 28 and stated the corridor			4/15/2025 the Maintenance			
		n 28 was five and a half feet			Supervisor/designee inspecte			
	wide.				location of all alcohol-based h			
					sanitizer dispensers and foun	nd no		
	These findings were				other negative findings.			
		he Maintenance Director			3 MEASURES TO PREVE	ENT		
	during the exit conf	Ference on 04/02/25.			REOCCURRENCE:			
					a On 4/17/2025 the			

3.1-19(b)

Administrator inserviced the Maintenance Supervisor/designee

05/06/2025 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 02 B. WING 04/02/2025 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2. Based on observation and interview, the facility on the requirement that failed to ensure alcohol based hand sanitizers alcohol-based hand sanitizers were not installed over an ignition source in 1 of cannot be installed where the over 50 resident sleeping rooms. NFPA 101, in corridor is at least 6 feet wide and 19.1.1.3 requires all health facilities to be designed, not over an ignition source to meet constructed, maintained and operated to minimize set standards. the possibility of a fire emergency requiring the Maintenance evacuation of occupants. This deficient practice Supervisor/designee will inspect could affect two residents, staff and visitors in all alcohol-based hand sanitizers resident sleeping Room 2. throughout the facility monthly to ensure they are in the proper Findings include: locations as a part of the facility's Preventive Maintenance Program Based on observations with the Maintenance and document those inspection Assistant at 11:21 a.m. on 04/02/25, an alcohol results as appropriate. If any based hand sanitizer dispenser was installed on issues are discovered, they will be the wall inside resident sleeping Room 2 directly addressed and resolved above a wall mounted electrical receptacle outlet immediately. The Maintenance box near the corridor door to the room. Supervisor/designee will review Manufacturer's documentation affixed to the with the Administrator the sanitizer solution inside the dispenser indicated it inspection results. was 80% ethyl alcohol by volume. Based on The Administrator will interview at 11:21 a.m. on 04/02/25, the monitor adherence to the Maintenance Assistant agreed an alcohol based Preventative Maintenance hand sanitizer was installed in resident sleeping schedule and validate the Room 2 on the wall directly above a wall mounted Preventative Maintenance outlet box in the room. documentation is in place. **MONITORING** These findings were reviewed with the **CORRECTIVE ACTION:** Administrator and the Maintenance Director The inspection results will during the exit conference on 04/02/25. be presented by the Maintenance Supervisor/designee to the 3.1-19(b)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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

the QA/PI Committee with

If continuation sheet

Page 16 of 34

PRINTED: 05/06/2025 FORM APPROVED

CENTERS FO	OMB NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155280	B. WING		04/02/2025	
NAME OF	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	0 05 011 00000 1	DOCC MANOR THE		LENOVER ST		
WATER	S OF DILLSBORO-I	ROSS MANOR, THE	DILLSI	BORO, IN 47018		
(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 APPROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				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	NFPA 101					
SS=F	Fire Alarm Syster	n Tosting and				
Bldg. 02	Maintenance	ii - Testing and				
Diag. 02		on and interview, the facility	K 0345	It is the intent of the facility to	04/23/2025	
		f 1 fire alarm systems was	K 0343	ensure fire alarm systems are	04/23/2023	
		rdance with LSC 9.6.1.3. LSC		maintained in accordance with		
		re alarm system to be installed,		LSC 9.6.1.3 to meet set		
	_	ned in accordance with NFPA		standards.		
	•	ical Code and NFPA 72,		1 CORRECTIVE ACTIONS		
		n Code. NFPA 72, Section		TAKEN:		
		that system defects and		a On 4/16/2025 the facility's		
	_	be corrected. This deficient		licensed fire alarm		
		et all residents, staff and		contractor/maintenance		
	1 ^	ers of Dillsboro building.		supervisor/designee made repa	irs	
		8		to the pull station to meet set		
	Findings include:			standards. The Administrator		
				verified the work on 4/16/2025.		
	Based on observation	ons with the Maintenance		2 ALL OTHERS WITH		
	Director during the	initial walk through of the		POTENTIAL TO BE AFFECTED	):	
	1	on 04/01/25, the main fire alarm		a All residents and all staff		
		corridor near the entrance to		and visitors have the potential to	o	
	1 -	dining area on the first floor of		be affected but none were.		
		boro building was in the		3 MEASURES TO PREVEN	т	
		vas silenced. Based on		REOCCURRENCE:		
	interview at 0.50 a	m on 04/01/25 the	1	2 On 4/17/2025 the		

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID:

TOHY21

Facility ID: 000178

Administrator in serviced the

on the requirement to ensure

Maintenance Supervisor/designee

If continuation sheet

Page 17 of 34

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155280	A. BUILDING B. WING	02	COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIER  OF DILLSBORO-F	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD  12803 LENOVER ST  DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	fire alarm system is necessary. Based or Maintenance Direct the main fire alarm trouble mode and w interview at 11:00 a Maintenance Direct has additional system system contractor is	e reviewed with the the Maintenance Director		proper maintenance of the fire alarm system to meet set standards.  b Maintenance Supervisor/Licensed Fire Alar Contractor/designee will ensu proper maintenance of the fire alarm system as a part of the facility's Preventive Maintenar Program and document those inspection results as appropriated in any issues are discovered, the will be addressed and resolve 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 where the presented by the Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The inspection results where the inspection results at the month Quality Assurance/Performant 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.	m re se conce cate. hely de se w w w w w w w w w w w w w w w w w w	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet

Page 18 of 34

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X	3) DATE SURVEY COMPLETED 04/02/2025
WATERS	PROVIDER OR SUPPLIE	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				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	Barrie Based on observatifailed to ensure 1 of would restrict the r 20 minutes. LSC 1 barriers shall comp 8.5.4.1 requires do the opening leaving necessary for proper practice could affer visitors in the vicin by the vending mare the employee break. Findings include:  Based on observation Assistant at 11:06 a smoke barrier door the first floor near to fully self close vitimes. The bottom floor when swinging on the floor before door was held in the wall mounted magnirelease with fire alse equipped with a se	ons with the Maintenance a.m. on 04/02/25, the single leaf by the vending machines on the employee break room failed when tested to close multiple of the door kept hitting the ag to close and became stuck it could fully self close. The ae fully open position with a metic hold open device set to arm system activation and was lf closing device. Based on a.m. on 04/02/25, the	K 0374	It is the intent of the facility to ensure smoke barrier doors wou restrict the movement of smoke at least 20 minutes to meet set standards.  1 CORRECTIVE ACTIONS TAKEN:  a On 4/15/2025 the Maintenance Supervisor/designerepaired the single leaf smoke barrier doors by the vending machines on the first floor near the employee break room to ensure 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 a smoke barrier doors throughout the facility and found no other negative findings.  3 MEASURES TO PREVENT REOCCURRENCE:	ee the it ne s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

If continuation sheet

Page 19 of 34

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       02       COMPLETED         B. WING       04/02/2025			ETED		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	_	
					ENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSB	ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oke barrier door failed to fully			a On 4/17/2025 the		
		large gap which would not			Administrator inserviced the		
		t of smoke for at least 20			Maintenance Supervisor/design		
	minutes.				and all staff the requirement the		
	These findings were	a raviawed with the			smoke barrier doors must clos		
		he Maintenance Director			completely to meet set standa b Maintenance	ius.	
	during the exit conf				Supervisor/designee will inspe	ect	
	and the one com				all smoke barrier doors through		
	3.1-19(b)				the facility monthly to ensure t		
	,				close completely and have no	-	
					impediments to closing as a p		
					of the facility's Preventive		
					Maintenance Program and		
					document those inspection re-	sults	
					as appropriate. If any issues	are	
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/design		
					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		
					CORRECTIVE ACTION:		
					a The inspection results w	ill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the	!	
					Administrator will present the		
					inspection results at the month	•	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	ру	
1					I THE LIVIEL COMMITTEE WITH		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet

Page 20 of 34

PRINTED: 05/06/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 02 155280 B. WING 04/02/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 **NFPA 101** SS=E Rubbish Chutes, Incinerators, and Laundry Bldg. 02 Chu Based on observation and interview, the facility K 0541 - It is the intent of the facility to 04/23/2025 failed to maintain 1 of 1 laundry chutes in ensure to maintain laundry chutes accordance with NFPA 82, Standard on in accordance with NFPA 82 to Incinerators and Waste and Linen Handling meet set standards. Systems and Equipment. LSC 9.5.2 requires **CORRECTIVE ACTIONS** laundry chutes shall be installed and maintained TAKEN: per NFPA 82, 2009 Edition. NFPA 82, Section On 4/15/2025 the 5.2.3.3.1.1 and Section 5.2.3.3.2.1 requires all chute Maintenance Supervisor/designee loading doors shall be provided with a repaired the door to soiled linen self-closing, positive latching frame and gasketed chute in the electrical room by door assembly. This deficient practice could Room 39 on the second floor to affect over 20 residents, staff and visitors on the ensure it latches into frame when second floor. self-closing to meet set standards. The Administrator Findings include: verified the work on 4/16/2025. **ALL OTHERS WITH** Based on observations with the Maintenance **POTENTIAL TO BE AFFECTED:** Director at 12:20 p.m. on 04/02/25, the door to the All residents and all staff soiled linen chute in the electrical room by Room and visitors have the potential to 39 on the second floor was equipped with a self be affected but none were.

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID:

TOHY21

Facility ID: 000178

**REOCCURRENCE**:

On 4/17/2025 the

Administrator inserviced the

Maintenance Supervisor/designee

and all staff on the requirement

If continuation sheet

**MEASURES TO PREVENT** 

Page 21 of 34

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	02	COMPLETED		
		155280	B. WING 04/02/2025				2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R			ENOVER ST			
WATERS	S OF DILLSBORO-I	ROSS MANOR, THE		DILLSBORO, IN 47018				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		loor failed to self close and			that self-closing hardware mus	st		
		frame when tested to close			have properly working latches	to		
	multiple times.				ensure closure to meet set			
					standards.			
	_	e reviewed with the			b Maintenance			
		the Maintenance Director			Supervisor/designee will inspe	ect		
	during the exit conf	ference on 04/02/25.			all self-closing hardware			
					throughout the facility monthly	to		
	3.1-19(b)				ensure they close properly as			
					part of the facility's Preventive			
					Maintenance Program and			
					document those inspection res			
					as appropriate. If any issues	are		
					discovered, they will be addre	ssed		
					and resolved immediately. Th			
					Maintenance Supervisor/desig	jnee		
					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			
					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			
					inspection results at the month	-		
					Quality Assurance/Performand			
					Improvement (QA/PI) meeting			
					Inspection results and system			
					components will be reviewed I	ру		
					the QA/PI Committee with			
					subsequent plans of correction			
					developed and implemented a	IS		
					deemed necessary to ensure			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21

Facility ID: 000178

If continuation sheet

Page 22 of 34

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 02 B. WING			(X3) DATE SURVEY COMPLETED 04/02/2025		
	PROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	<u> </u>		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	l I	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					compliance is maintained. This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 4/23/2025.		
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills						
Jug. 02	failed to document a system on fire drills and 9:00 p.m. on the LSC 19.7.1.4 states occupancies shall in fire alarm signal and conditions. When do 9:00 p.m. (2100 hou coded announcement used instead of audit practice could affect visitors in the facility.  Findings include:  Based on review of documentation with 1:30 p.m. on 04/01/shift fire drill conduct third quarter (July, a indicated the drill we conducted after 6:00 did not document act system and transmiss the time of the fire of shift fire drill documents of "Silent actions on the system and transmiss the time of the fire of shift fire drill documents or "Silent actions of the system and transmiss the time of the fire of shift fire drill documents or "Silent actions of the system and transmiss the time of the fire of shift fire drill documents or "Silent actions of the system and transmiss the time of the fire of shift fire drill documents of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the time of the sile of the system and transmiss the sile of the system and transmiss the sys		K 07	12	It is the intent of the facility to ensure to document activation the fire alarm system on fire of conducted between 6:00 am 9:00 pm on the first shift for a quarters to meet set standard 1 CORRECTIVE ACTION TAKEN:  a On 4/17/2025 the Administrator inserviced Maintenance Supervisor on the proper fire drill procedures and conducted fire training for all members to meet set standard 2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all state and visitors have the potential be affected but none were.  3 MEASURES TO PREVENTIAL TO BE AFFECT a On 4/17/2025 the Administrator inserviced the Maintenance Supervisor/all ston the requirement to ensure staff are familiar with and understand the fire drill policy procedures to meet set standard busintenance	n of drills and ll 4 ds. S  he dd staff rds.  ED: ff ll to ENT  taff all	04/23/2025

i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	02	COMPLETED	
		155280	B. W	ING		04/02/	2025
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
				12803 L	LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSB	3ORO, IN 47018		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		to "Transmission of alarm to			Supervisor/Administrator/design	-	
		y/Fire Dept?". The 07/24/24			will ensure all staff are familia		
		ocumentation also stated the			and understand the fire drill po	•	
		at 1:15 a.m. Based on			and procedures as a part of th	ie	
	interview at 1:30 p.				facility's monthly Preventive		
		for stated the 07/24/24 fire drill			Maintenance Program and		
		drill conducted at 1:15 p.m. not			document those inspection res		
		ty operates three shifts per day			as appropriate. If any issues		
		4/24 first shift fire drill			discovered, they will be addre		
	_	.m. did not include activation			and resolved immediately. Th		
	-	stem and transmission of the			Maintenance Supervisor/desig	•	
	fire alarm signal at	the time of the fire drill.			will review with the Administra	itor	
		· a va a			the inspection results.		
	These findings were				c The Administrator will		
		he Maintenance Director			monitor adherence to the		
	during the exit conf	erence on 04/02/25.			Preventative Maintenance		
	2.1.10(1)				schedule and validate the		
	3.1-19(b)				Preventative Maintenance		
	3.1-51(c)				documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The fire drill documentat	ion	
					will be presented by the		
					Maintenance Supervisor/designs to the Administrator monthly of	•	
					to the Administrator will present		
					the Administrator will present		
					inspection results at the month	•	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting Inspection results and system		
					components will be reviewed l		
					the QA/PI Committee with	Бу	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure	40	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.	•	

155280 DSS MANOR, THE			04/02/2025		
OSS MANOR THE					
333 1111 1112		TREET ADDRESS, CITY, STATE, ZIP COD 2803 LENOVER ST ULLSBORO, IN 47018			
TATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
SC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		Our date of compliance is 4/23/2025.			
- Maintenance and					
ew and interview, the facility mentation of electrical outlet all resident sleeping rooms fordance with NFPA 99. The Facilities Code, 2012 1.1.3 states receptacles not the at patient bed locations are deep sedation or general sted at intervals not at intervals not and in each electrical receptacle shall be all installation, replacement or the each electrical receptacle shall be an each electrical receptacle receptacle and retention force of the each electrical receptacle receptacles) shall be not less notes). Section 6.3.4.2.1.2 the record shall contain the east tested, and an indication met, or have failed to meet, irrements of this chapter.	K 0914	ensure documentation of election outlet receptacle testing for a resident sleeping rooms is completed in accordance with NFPA 99 to meet set standard 1 CORRECTIVE ACTION TAKEN:  a On 4/15/2025 the Maintenance Supervisor completed the annual resider room receptacle testing included documenting the results of inspection and testing for the continuity of the grounding cirthe correct polarity and also to 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 AFFECTION and visitors have the potential be affected but none were.  3 MEASURES TO PREVIOUS REOCCURRENCE:  a On 4/17/2025 the Administrator inserviced the Maintenance Supervisor/designature.	ds.  S  tt ding cuit, ne h  k  ED: f I to ENT		
- Transcript of the second of	Maintenance and  w and interview, the facility mentation of electrical outlet all resident sleeping rooms ordance with NFPA 99.  e Facilities Code, 2012  .1.3 states receptacles not the at patient bed locations the edep sedation or general sted at intervals not NFPA 99, Health Care Edition, Section 6.3.4.1.1 receptacles testing shall be a installation, replacement or the electrical receptacle shall be a spection. The continuity of the hot and the each electrical receptacle receptacle shall be not electrical receptacle receptacles). Section 6.3.4.2.1.2 the record shall contain the as tested, and an indication met, or have failed to meet, irements of this chapter.  Monthly Receptacle  Monthly Receptacle	Maintenance and  We and interview, the facility mentation of electrical outlet all resident sleeping rooms ordance with NFPA 99.  The Facilities Code, 2012  1.1.3 states receptacles not le at patient bed locations et deep sedation or general sted at intervals not NFPA 99, Health Care Edition, Section 6.3.4.1.1 receptacles testing shall be linstallation, replacement or e. Section 6.3.3.2, Patient Care Rooms requires of each receptacle shall be enspection. The continuity of in each electrical receptacle receptacles) shall be not less nees). Section 6.3.4.2.1.2 the record shall contain the as tested, and an indication met, or have failed to meet, irrements of this chapter. esidents, staff and visitors.	DILLSBORO, IN 47018  ATEMENT OF DEFICIENCIE / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION  Maintenance and  w and interview, the facility mentation of electrical outlet all resident sleeping rooms ordance with NFPA 99. e Facilities Code, 2012 .1.3 states receptacles not e at patient bed locations e deep sedation or general ted at intervals not NFPA 99, Health Care Edition, Section 6.3.4.1.1 receptacles testing shall be Linstallation, replacement or e. Section 6.3.3.2, Patient Care Rooms requires of each receptacle shall be respection. The continuity of ine ach electrical receptacle are tention force of the ch electrical receptacle and retention force of the ch electrical receptacle in each electrical receptacle and retention force of the ch electrical receptacle and retention force of the ch electrical receptacle in each electric		

05/06/2025 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 02 B. WING 04/02/2025 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE twelve month period with the Maintenance electrical receptacle testing must Director at 1:06 p.m. on 04/01/25, electrical be completed annually and receptacle inspection and testing documentation documented in the life safety for all resident sleeping rooms within the most binder to meet set standards. recent twelve month period was incomplete. The Maintenance monthly inspection documentation indicated it Supervisor/designee will ensure was a "visual inspection to ensure receptacles are the annual electrical receptacle secured and no defects" but did not list the testing is completed and results of inspection and testing for the continuity documented as a part of the of the grounding circuit, the correct polarity and facility's Preventive Maintenance also did not list retention force testing for each Program and document those electrical receptacle tested. Based on interview at inspection results as appropriate. 1:06 p.m. on 04/01/25, the Maintenance Director If any issues are discovered, they stated additional receptacle testing will be addressed and resolved documentation for the most recent twelve month immediately. The Maintenance period was not available for review, each resident Supervisor/designee will review sleeping room may have a mix of hospital grade with the Administrator the and non-hospital grade receptacles installed in the inspection results. room and agreed monthly electrical receptacle The Administrator will testing documentation did not list the results of monitor adherence to the inspection and testing for the continuity of the Preventative Maintenance grounding circuit, the correct polarity and also did schedule and validate the not list retention force testing for each electrical Preventative Maintenance receptacle tested. documentation is in place. MONITORING These findings were reviewed with the **CORRECTIVE ACTION:** Administrator and the Maintenance Director The inspection results will during the exit conference on 04/02/25. be presented by the Maintenance Supervisor/designee to the 3.1-19(b) 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 X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIE S OF DILLSBORO-	R ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
				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.	1
K 0920 SS=D Bldg. 02	Extens Based on observatifailed to ensure nor were not used as a of over 60 resident requires utilities to 9.1.2 requires elect comply with NFPA 2011 Edition. NFF unless specifically cables shall not be wiring of a structur building service eq for life safety shall approved in accord standards. This de residents, staff and sleeping Room 63.  Findings include:  Based on observatifassistant at 10:55 cell phone charging reclining chair were adaptor plugged in mounted outlet box	on and interview, the facility in-fused multiplug adapters substitute for fixed wiring in 1 sleeping rooms. LSC 19.5.1 comply with Section 9.1. LSC rical wiring and equipment to a 70, National Electrical Code, PA 70, Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed re. LSC Section 4.5.7 states any uipment or safeguard provided be designed, installed and lance with all applicable NFPA ficient practice could affect 2 visitors in the resident  ons with the Maintenance a.m. on 04/02/25, a telephone, a g cable and an electric powered e plugged into a multiplug to a receptacle in the wall a near the resident bed nearest 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 me set standards.  1.CORRECTIVE ACTIONS TAKEN:  1.On 4/15/2025 the Maintenance Supervisor/designemoved the multiplug adaptoresident room 63 to meet set standards. The Administrator verified the removal on 4/16/2 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all state and visitors have the potential be affected but none were. O 4/15/2025 the Maintenance Supervisor/designee inspected rooms throughout the facility formultiplug adaptors and found other negative findings.  3.MEASURES TO PREVENT REOCCURRENCE:  1.On 4/17/2025 the	gnee r in  025.  ED:  ff to n d all or no

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 27 of 34

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	COMPLETED 04/02/2025			
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018					
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ection (X5) ULLD BE COMPLETION DATE			
TAG	Based on interview Maintenance Assis adaptor was being wiring in resident s  These findings wer Administrator and	at 10:55 a.m. on 04/02/25, the tant agreed a multiplug used as a substitute for fixed	TAG	Administrator inserviced Maintenance Supervisor/designee/all that multiplug adaptors a be used as a substitute wiring to meet set stand 2.Maintenance Supervisor/designee wil all rooms throughout the monthly to ensure they chave multiplug adaptors a part of the facility's Presented by the Maintenance Program a document those inspect as appropriate. If any is discovered, they will be and resolved immediate Maintenance Supervisor will review with the Admithe inspection results.  3. The Administrator monitor adherence to the Preventative Maintenance Supervisor will review Maintenance Supervisor will review Maintenance Supervisor will review Maintenance to the Preventative Maintenance Supervisor adherence to the Preventative Maintenance Supervisor and Supervisor	other staff are not to for fixed ards.  I inspect e facility do not in use as eventive and ion results assues are addressed ly. The tr/designee inistrator  r will e ce ne ce te. RECTIVE  esults will intenance the monthly ormance eeting. ystem ewed by ith			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 28 of 34

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED	
155280		B. WING 04/02/2025			2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATION  (EACH CORRECTION SHOULD BE  (EACH CORRECTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATION  (EACH CORRECTION SHOULD BE  (EACH CORRECTION SHOULD BE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
					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 4/23/2025.		
K 0921 SS=F Bldg. 02	interview; the facilit required maintenand documentation of in Related Electrical E Health Care Faciliti 10.3 and 10.5 states resistance, leakage of tests for fixed and prequired in 10.3. Te with policies and prepatient care rooms in 10.3.5.4 or 10.3.6 be after any repair or not consisting of several demonstrates complete system. So and procedures provinclude information are considered in the for electrical equipment instruction are readily available condensed operating	ent - Testing and  riew, observation and ty failed to conduct the ce and maintain complete aspections for all Patient Care (quipment (PCREE). NFPA 99, es Code, 2012 edition, sections the physical integrity, current, and touch current ortable PCREE is performed as sting intervals are established otocols. All PCREE used in s tested in accordance with efore being put into service and nodification. Any system I electrical appliances liance with NFPA 99 as a service manuals, instructions, wided by the manufacturer as required by 10.5.3.1.1 and e development of a program ment maintenance. Electrical ons and maintenance manuals e, and safety labels and g instructions on the e. A record of electrical	K 0!	921	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 standard 1.CORRECTIVE ACTIONS TAKEN:  1.On 4/14/2025 and 4/15/2025 the facility's trained Regional Property Managers we conduct PCREE testing on the other PCREE in the facility including: electric beds, nebulizers, oxygen concentrativital sign monitors, and other electrical medical equipment to meet set standards. The Administrator verified the work 4/16/2025.  2.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all stand visitors have the potential	vill ors, o con	04/23/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 29 of 34

ABUIDNO DENTECATION NUMBER 155280 SPELET O4/02/2025  NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR, THE  CAJ ID SIMMARY STATIMENT OF DIRECTROCE (EACH DESICIENCY MUST BE PRECEDED BY FULL TAG (EACH DESICIENCY MUST BE PRECEDED BY FULL PROPERTY AND ACCOUNTY OR IS DESTRUCTION INFORMATION (EACH DESICIENCY MUST BE PRECEDED BY FULL PROPERTY AND ACCOUNTY OR IS DESTRUCTION INFORMATION TO ACCOUNTY OR IS DESTRUCTED TO ACCOUNTY OR IS	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
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3.1-19(b) Supervisor/designee to the		daring the exit conference on 07/02/23.						
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I Administrator monthly and the		5.1 17(0)				Administrator monthly and th	e	
Administrator monthly and the Administrator will present the								
inspection results at the monthly						<u> </u>		
Quality Assurance/Performance						I	-	
Improvement (QA/PI) meeting						-		

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155280		r í	ILDING	onstruction 02	(X3) DATE COMPL <b>04/02</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(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)	TE	(X5) COMPLETION DATE
					Inspection results and system components will be reviewed I 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 4/23/2025.	by n as	
K 0000							
Biag. U3	Licensure Survey w Department of Heal 483.90(a).  Survey Date(s): 04/ Facility Number: 0 Provider Number: 100 At this Life Safety 0 Dillsboro-Ross Mar compliance with Re Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code, C Occupancies and 41 The Waters of Dills	273840  Code survey, The Waters of nor was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, Chapter 19, Existing Health Care 10 IAC 16.2.	K 00	000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in generor this corrective action, does constitute an admission or agreement by this facility of the facts alleged or conclusions seforth in this statement of deficiencies. The plan of correction and specific correct actions are prepared and/or executed in compliance with seand federal laws. This plan of correction constitutes a writter allegation of substantial compliance with Federal Mediand Medicaid requirements.	ral, not e et ive tate	
K 0000 Bldg. 03	Licensure Survey w Department of Heal 483.90(a).  Survey Date(s): 04/ Facility Number: 0 Provider Number: 100 At this Life Safety 0 Dillsboro-Ross Mar compliance with Re Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code, C Occupancies and 41 The Waters of Dills	ras conducted by the Indiana lth in accordance with 42 CFR  201/25 & 04/02/25  200178  155280  273840  Code survey, The Waters of mor was found not in equirements for Participation in 4, 42 CFR Subpart 483.90(a), are and the 2012 edition of the ection Association (NFPA) 101, Chapter 19, Existing Health Care 10 IAC 16.2.	K 00	000	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.  DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in gener or this corrective action, does constitute an admission or agreement by this facility of th facts alleged or conclusions so forth in this statement of deficiencies. The plan of correction and specific correct actions are prepared and/or executed in compliance with s and federal laws. This plan of correction constitutes a writter allegation of substantial compliance with Federal Medi	of ral, not e tate tate	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 31 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION   (X3) DATE SURVEY						
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			12803	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
K 0363	and was determined construction and ful Building 03, is a on determined to be Ty fully sprinklered. E system with smoke Waters of Dillsboro building including the corridors, and hidetectors in all resid Waters of Dillsboro building. The Waters a capacity of 12 the time of this visit All areas where residence were sprinkled and services were sprinkled and services were sprinkled control of the time of this visit was a capacity of 12 the time of this visit was a capacity of 12 the time of this visit were sprinkled and services were sprinkled control of the time of the time of this visit was a capacity of 12 the time of this visit wa	idents have customary access all areas providing facility						
SS=E Bldg. 03	failed to ensure 1 of sleeping rooms in R passage of smoke. affect over 10 resident vicinity of resident Manor.  Findings include:  Based on observation Director at 2:25 p.m was noted in between and the door stop of sleeping rooms.	on and interview, the facility of 25 corridor doors to resident closs Manor would resist the This deficient practice could ents, staff and visitors in the sleeping Room 10 in Ross  ons with the Maintenance on on 04/01/25, a 3/4th's inch gap en the face of the corridor door on the door frame to resident on Ross Manor when the door	K 0363	It is the intent of the facility to ensure corridor doors to resid sleeping rooms in Ross Mand would resist the passage of smoke to meet set standards  1 CORRECTIVE ACTION TAKEN:  a On 4/15/2025 the Maintenance Supervisor/desirepaired Resident room 10 door/door frame to meet set standards. The Administrator verified the repair on 4/16/2022  2 ALL OTHERS WITH POTENTIAL TO BE AFFECT	gnee			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TOHY21 Facility ID: 000178

If continuation sheet Page 32 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 04/02/2025 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (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 was in the fully closed and latched position. A All residents and all staff notch had been cut out of the latching plate on and visitors have the potential to the door frame which caused the latching be affected but none were. The mechanism on the door frame to protrude into its Maintenance Supervisor/designee opening on the door frame but not into its inspected all doors and found no intended more restrictive opening for the latching other negative findings. plate which caused a gap of greater than 1/4th's **MEASURES TO PREVENT** inch for a sprinklered building. Based on REOCCURRENCE: interview at 2:25 p.m. on 04/01/25, the On 4/17/2025 the Maintenance Director agreed a notch had been Administrator in serviced the cut out of the latching plate on the door frame Maintenance Supervisor/All staff which caused a gap in between the face of the on the requirement to ensure corridor door to resident sleeping Room 10 and corridor doors close, latch into the the door stop on the door frame which would not door frame and ensure there are resist the passage of smoke. no gaps to meet set standards. Maintenance These findings were reviewed with the Supervisor/designee will ensure Administrator and the Maintenance Director corridor doors close. latch into the during the exit conference on 04/02/25. door frame and ensure there are no gaps as a part of the facility's 3.1-19(b) 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. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **MONITORING CORRECTIVE ACTION:** The inspection results will be presented by the Maintenance Supervisor/designee to the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/02/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE		
				Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand 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 4/23/2025.	hly ce J. by n as		

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