CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155202	B. WING		09/06/2023	
		100202		<u> </u>	00/00/2020	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD OSPITAL DR		
WATERS	OF GREENCASTI	LE, THE	GREENCASTLE, IN 46135			
(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	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
E 0000 Bldg E 0041 SS=C Bldg	An Emergency Preponducted by the In accordance with 42 Survey Date: 09/06 Facility Number: 0 Provider Number: 1000 At this Emergency I Waters of Greencas compliance with En Requirements for M Participating Provides 483.73 The facility has a cand had a census of Quality Review con 482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency an	paredness Survey was diana Department of Health in CFR 483.73. 200109 155202 266290 Preparedness survey, The tle was found in substantial mergency Preparedness Iedicare and Medicaid lers and Suppliers, 42 CFR apacity of 100 certified beds 262 at the time of this visit.	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wi Federal Medicare and Medicaid requirements.	t the set red ice	
	standby power systemergency plan southis section and in procedures plan southis and (ii) of this southis satisfies \$483.73(e), \$485.0(e) Emergency and The [LTC facility and section of the section of th	etems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.				

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

TITLE (X6) DATE

Jennifer Etienne Administrator 09/23/2023

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.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	r í	ILDING	NSTRUCTION	(X3) DATE COMPL 09/06/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135					
(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	
		n the emergency plan set (a) of this section.						
	Emergency gener generator must be the location require Care Facilities Counterim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §48. Emergency gener The [hospital, CAI	83.73(e)(1), §485.625(e)(1) rator location. The relocated in accordance with rements found in the Health rements f						
	inspection, testing requirements four	g, and [maintenance] nd in the Health Care FPA 110, and Life Safety						
	Emergency gener and LTC facilities source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the sit evacuates.						
	§483.73(g), and C The standards inc this section are ap reference by the I Federal Register	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain						

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Event ID:

TQRI21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING CO			ETED
		155202	B. W	ING		09/06	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8		1	OSPITAL DR		
WATERS	S OF GREENCAST	LE, THE			ICASTLE, IN 46135		
	1		1		,		(V.5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG				IAU			DATE
	the material from the sources listed below. You may inspect a copy at the CMS						
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
	, ,	ARA, call 202-741-6030, or					
	go to:	,					
	•	es.gov/federal_register/code					
	_of_federal_regul	ations/ibr_locations.html.					
	If any changes in	this edition of the Code are					
	incorporated by reference, CMS will publish a						
	document in the Federal Register to						
	announce the cha	inges.					
	(1) National Fire F	Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
		th Care Facilities Code,					
		ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	<u> </u>					
	(III) TIA 12-3 to NE 2012.	FPA 99, issued August 9,					
	_	FPA 99, issued March 7,					
	2013.	-PA 99, ISSUEU MAICH 7,					
		PA 99, issued August 1,					
	2013.	1 A 99, Issued August 1,					
		FPA 99, issued March 3,					
	2014.						
		fe Safety Code, 2012					
	edition, issued Au	-					
		IFPA 101, issued August					
	11, 2011.	-					
	(ix) TIA 12-2 to NI	FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NF	PA 101, issued October					
	22, 2013.						
	(xi) TIA 12-4 to NI	FPA 101, issued October					
	22, 2013.						

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2023	
	PROVIDER OR SUPPLIER S OF GREENCAST		STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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	
	(xiii) NFPA 110, S Standby Power Sincluding TIAs to a 2009 Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice of Findings include: Based on record revolution for a 10/24/22 weekly go available for review time of record review weekly generator to the aforementioned	standard for Emergency and systems, 2010 edition, chapter 7, issued August 6, eview and interview, the facility of the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This could affect all occupants. Wiew with the Administrator on a.m. to 12:15 p.m., the weeks of 09/26/22 and emerator testing was not over the Administrator confirmed esting was not documented on	E 0041	E041– It is the intent of the facto ensure to implement the emergency power system requirements found in the heat care facilities code, NFPA 110 and Life Safety Code in accordance with 42 CFR 483. (e)(2) to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. The Administrator will in-service the new Maintenand Supervisor/designee on September 29, 2023 on the requirement to perform weekly inspections of the emergency generator and document the results in the facilities Life Saf Binder to meet set standards. b. On September 9, 2023 Maintenance Supervisor/designer formed the weekly inspections of the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all state and visitors have the potential be affected but none were. 3. MEASURES TO PREVENCE: a. The Maintenance Supervisor/designee will ensure weekly inspections on the	cility 09/09/2023 Ith 0 73 S ce y ety the gnee on of ED: ff to ENT	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2023	
	ROVIDER OR SUPPLIE		1601 H	ADDRESS, CITY, STATE, ZIP COD OSPITAL DR NCASTLE, IN 46135	
	OF GREENCAST SUMMARY (EACH DEFICIEN		1601 H	OSPITAL DR	icy in the icy ds. ented eator is at A/PI) by n is
K 0000 Bldg. 01				Our date of compliance is September 9, 2023.	

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STATEMENT 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>01</u> CO			ETED
		155202	B. W.	B. WING 09/06/2023			2023
				CERCE	A DDDDGG GITTY GT ATE TID GOD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED		LE TUE			OSPITAL DR		
WATERS	S OF GREENCAST	LE, IHE		GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TION TAG		DEFICIENCY)		DATE
	A Life Safety Code	Recertification and State	K 0	000	DISCLAIMER STATEMENT:		
	Licensure Survey w	vas conducted by the Indiana		Preparation and/or execut		ı	
	Department of Health in accordance with 42 CFR				of this plan of correction in		
	483.90(a).				general, or this corrective		
	Survey Date: 09/06/23				action in particular, does not	t	
					constitute an admission or		
					agreement by this facility of	the	
	Facility Number: 0				facts alleged or conclusions	set	
	Provider Number: 155202 AIM Number: 100266290				forth in this statement of		
					deficiencies. The plan of		
					correction and specific		
		Code survey, The Waters of			corrective actions are prepar	red	
		ound not in compliance with			and/or executed in complian	ce	
	Requirements for Participation in				with state and federal laws.		
		l, 42 CFR Subpart 483.90(a),			This plan of correction		
	-	re, and the 2012 edition of the			constitutes a written allegati		
		ction Association (NFPA) 101,			of substantial compliance wi	ith	
		LSC), Chapter 19, Existing			Federal Medicare and		
	Health Care Occupa	ancies and 410 IAC 16.2.			Medicaid requirements.		
	· ·	etermined to be of Type V (111)					
		as fully sprinklered. The					
	•	arm system with smoke					
		ridors, spaces open to the					
		ry operated smoke detectors in					
		g rooms. The facility has a					
		I had a census of 62 at the time					
	of this survey.						
	All areas where res	idents have customary access					
		all areas providing facility					
	_	klered except for three					
	_	t storage sheds which were					
	not sprinklered.	-					
	Quality Review cor	mpleted on 09/11/23					
K 0300	NFPA 101						
SS=C	Protection - Other						
Bldg. 01	Protection - Other						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/06/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(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)	(X5) COMPLETION DATE
	Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included 1. Based on record facility failed to ensemaintenance for all in resident rooms we manufacturer's public in 4.6.12.3 states expossion to the public shall be maintained and Tests. Fire-warm maintained and test manufacturer's public requirements of Challes Inspection, testing, shall satisfy the req	are not addressed by the out are deficient. This with the applicable Life FPA standard citation, don Form CMS-2567. review and interview, the outer the preventative battery operated smoke alarms as conducted according to ished instructions. NFPA 101 isting life safety features c, if not required by the Code, of NFPA 72, 29.10 Maintenance oning equipment shall be ead in accordance with the ished instructions and per the apter 14. NFPA 72, 14.2.1.1.1 and maintenance programs different soft this Code and poment manufacturer's of this Code and poment manufacturer's of this Code and poment manufacturer's ns. This deficient practice dents. View with the Administrator of a.m., the "Battery-Operated different power of the battery operated smoke acturer's published instructions in 19040 smoke alarms stated the city testing. Based on interview its review, the Administrator is tested monthly, and agreed it etested weekly according to	K 0300	K300— It is the intent of the fit to ensure the preventative maintenance for all battery operated smoke alarms in rerooms is conducted according manufacturer's published instructions and to ensure documentation for the preventant maintenance of battery operations and to ensure documentation for the preventant maintenance of battery operations and to ensure documentation for the preventant maintenance of battery operations and to ensure documentation for the preventant maintenance alarms in the facility is complete to meet set standard. 1) CORRECTIVE ACTION TAKEN: a) The Administrator will in-service the new Maintenance Supervisor/designee on September 29, 2023 on the requirement that battery operated and documentation retained at the facility to meet set standards by On September 16, 202 Maintenance Supervisor/designed of the battery-operated smoke alarms and documented the information on the Battery-Operated Smoke Definition on the Battery-Operated Smoke Definition on the Battery-Operated Smoke Definition on September 16, 202 Maintenance Log to meet set standards. The Administrator verified the work on September 16 and the prevention of the Battery-Operated Smoke Definition on the Battery-Operated Smoke	esident ag to entative ated so rated tained so and decided so and decided so tector at the correction of the correction are entated to rector at the correction at the correction at the correction at the correction are entated to rector at the correction at t

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/06/2023	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	
WATERS	S OF GREENCAST	LE, THE			IOSPITAL DR NCASTLE, IN 46135	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	<u> </u>	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	and Director of Nu	rsing during the exit			2023.	
	conference.				c) The Administrator will	
					in-service the new Maintenand	ce
	2. Based on record	l review, interview and			Supervisor/designee on	
		cility failed to ensure			September 29, 2023 on the	
	documentation for	the preventative maintenance			requirement that all 48 battery	
		operated smoke alarms in the			operated smoke alarms must l	be
		ete. NFPA 101 in 4.6.12.3 states			tested per manufacture's	
		features obvious to the public,			guidelines and documentation	
		he Code, shall be maintained.			retained at the facility to meet	set
	NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's				standards.	
					2) ALL OTHERS WITH	
					POTENTIAL TO BE AFFECTE	
	published instructions and per the requirements				a) All residents and all staf	
	_	PA 72, 14.2.1.1.1 Inspection,			and visitors have the potential	to
	_	nance programs shall satisfy			be affected but none were.	
	_	f this Code and conform to the			3) MEASURES TO PREVE	NT
		cturer's published instructions.			REOCCURRENCE:	
	_	tice could affect all residents,			a) Maintenance	
	staff, and visitors.				Supervisor/designee will ensur	
	F' 1' ' 1 1				battery-operated smoke alarm	
	Findings include:				are maintained per manufactu	
	Dagad on marriage at	f the Battery Operated Smoke			guidelines and tested on a we	екіу
		nce Log on 09/06/23 from 89:35			basis and will document the	٠. ا
		testing for 24 of the 48 battery			results on the Battery-Operate Smoke Detector Maintenance	
	_	arm was not documented July			to be filed in the Life Safety Bi	
	_	Based on interview at the time			as a part of the facility's Preve	
	_	ninistrator confirmed the testing			Maintenance Program. If any	
	· ·	operated smoke detectors in			issues are discovered, they wi	
		of documented for July and			addressed and resolved	
		ng the Maintenance Director			immediately. The Maintenance	e
		documenting the second page.			Supervisor/designee will review	
		ons between 12:15 p.m. and			with the Administrator the	
		tour of the facility with the			inspection results.	
		Director of Nursing, battery			b) The Administrator will	
		irms were observed in all			monitor adherence to the	
	resident sleeping ro				Preventative Maintenance	
					schedule and validate the	
	This finding was re	eviewed with the Administrator			Preventative Maintenance	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		A. BUILDING B. WING	01	COMPLETED 09/06/2023	
	ROVIDER OR SUPPLIER		1601 H	ADDRESS, CITY, STATE, ZIP COD OSPITAL DR NCASTLE, IN 46135	
(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
	and Director of Nurs 3.1-19(b)	sing at the exit conference.		documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results we be presented by the Maintena 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 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 September 16, 2023.	nily ce by
K 0351 SS=D Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II conprotection measure substituted for sprinklers.	Installation nd hospitals where required			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/06/2023 155202 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1601 HOSPITAL DR WATERS OF GREENCASTLE, THE GREENCASTLE, IN 46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility K 0351 **K351** - It is the intent of the facility 09/07/2023 failed to maintain the ceiling construction in to ensure to maintain the ceiling accordance with NFPA 13, Standard for the construction in rooms in Installation of Sprinkler Systems. NFPA 13, 2010 accordance with NFPA 13. edition, Section 6.2.7.1 states plates, escutcheons, Standard for the installation of or other devices used to cover the annular space sprinkler systems to meet set around a sprinkler shall be metallic or shall be standards. listed for use around a sprinkler. This deficient 1 **CORRECTIVE ACTIONS** practice could affect 2 residents. TAKEN: On September 7, 2023 a Findings include: Certified Sprinkler Contractor/Maintenance Based on observations and interview during a Supervisor/designee installed the tour of the facility with the Administrator and missing escutcheon ring on the Director of Nursing on 09/06/23 between 12:15 sprinkler head in resident room p.m. and 1:35 p.m., the sprinkler head in resident 119 to meet set standards. The room 119 was missing an escutcheon and did not Administrator verified the completely cover the hole around the sprinkler. installation on September 7, Based on interview at the time of observation, the 2023. Administrator agreed the aforementioned area was **ALL OTHERS WITH** missing an escutcheon. POTENTIAL TO BE AFFECTED: All residents and all staff This finding was reviewed with the Administrator and visitors have the potential to and Director of Nursing at the exit conference. be affected but none were. **MEASURES TO PREVENT** 3 3.1-19(b) REOCCURRENCE: The Administrator will in-service the new Maintenance Supervisor/designee on

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155202	B. WING 09/06/2023			/2023	
		l		CTD DET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\\\\ TEDG	COECDEENCAST	E THE			OSPITAL DR ICASTLE, IN 46135		
VVATERS	OF GREENCAST	LE, INE		GKEEN			
(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
					requirement that ceiling moun	ted	
					sprinkler locations must be		
					maintained including the		
					escutcheon ring installed to m	eet	
					set standards.		
					b. Maintenance		
					Supervisor/designee will inspe	ect	
					all sprinkler heads monthly to		
					ensure they are maintained ar		
					have the escutcheon ring insta		
					as a part of the facility's month	-	
					Preventive Maintenance Progr		
					and document those inspectio		
					results as appropriate. If any		
					issues are discovered, they wi	ш ре	
					addressed and resolved		
					immediately. The Maintenand		
					Supervisor/designee will revie with the Administrator the	vv	
					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	nly	
					Quality Assurance/Performand	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I		
					the QA/PI Committee with		

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subsequent plans of correction

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		A. BUILDING B. WING	01	COMPLETED 09/06/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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	
				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 September 7, 2023.		
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkle	supply source RKS information on non-required or partial r system.				
	failed to maintain at accordance with NF sprinkler systems sh maintained in accor for the Inspection, T Water-Based Fire P 2011 Edition, Section	iew and interview, the facility atomatic sprinkler systems in PA 25. LSC 9.7.5 requires all hall be inspected, tested, and dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, on 4.1.4.1 states the property I representative shall correct	K 0353	K353 – It is the intent of the facility to ensure to maintain automatic sprinkler systems in accordance with NFPA 25 to n set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On October 10, 2023 th	neet	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		IDENTIFICATION NUMBER	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 09/06/2023	
NAME OF F	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD	•		
	OF GREENCAST			1601 HOSPITAL DR GREENCASTLE, IN 46135				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	or repair deficiencies or impairments that are				facilities Certified Sprinkler			
	_	spection, test and maintenance			Contractor will conduct the dr	•		
		ndard. Corrections and repairs			pipe fire sprinkler system flus	h		
	_	by qualified maintenance			that was noted on the 09/14/2			
		ified contractor. NFPA 25,			inspection report and docume	ented		
	_	rds shall be made for all			the results to meet set standa			
	_	and maintenance of the system			The Administrator will verify the	ne		
		all be made available to the			work on October 10, 2023.			
		risdiction upon request. This			2.ALL OTHERS WITH			
	1 ^	ould affect all residents, staff,			POTENTIAL TO BE AFFECT	ED:		
	and visitors in the	facility.			1.All residents and all sta			
	Findings include:				and visitors have the potentia	l to		
					be affected but none were.			
					3.MEASURES TO PREVEN	Т		
		f "Sprinkler: Five Year Internal			REOCCURRENCE:			
	Pipe Inspection" do	ocumentation dated 09/07/22			1.The Administrator will			
	during record revie	w with the Administrator from			in-service the new Maintenan	ce		
	9:35 a.m. to 12:15	p.m. on 09/06/23, the inspection			Supervisor/designee on			
	results stated 'Foun	d rust scale inside of fire			September 29, 2023 the			
	sprinkler piping an	d recommend that dry pipe fire			requirement that the deficience	cies		
	sprinkler system be	e flushed'. Based on interview			noted on the sprinkler inspect	ion		
	at the time of recor	d review, the Administrator			report must be corrected and			
		through emails and produced			documented to meet set			
	_	5/23 and quote expiration date			standards.			
		ming a complete dry pipe fire			2.Maintenance			
	1 ^	ush but no work had been			Supervisor/designee will ensu			
		rmed since 09/07/22. Prior to			deficiencies noted on the spri	nkler		
		, the Administrator provided a			inspection report are correcte			
		/06/23 from the facility's			a part of the facility's Preventi	ve		
		n vendor that stated 'scheduled			Maintenance Program and			
	_	e sprinkler system flush at the			document those inspection re			
		ty, on Tuesday October 10,			as appropriate. If any issues			
	2023.'				discovered, they will be addre			
					and resolved immediately. The			
	_	eviewed with the Administrator			Maintenance Supervisor/design	gnee		
	and Director of Nu	rsing at the exit conference.			will review with the Administra	ator		
					the inspection results.			
	3.1-19(b)				3.The Administrator will			
					monitor adherence to the			
					Preventative Maintenance			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/06/2023
	PROVIDER OR SUPPLIE		1601 H	ADDRESS, CITY, STATE, ZIP COD IOSPITAL DR NCASTLE, IN 46135	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE
				schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORREACTION: 1.The inspection rest be presented by the Maint Supervisor/designee to the Administrator monthly and Administrator will present inspection results at the magnetion results at the magnetion results and system components will be review the QA/PI Committee with subsequent plans of corredeveloped and implement deemed necessary to ension constitutes our credible allegation of compliance all regulatory requiremer Our date of compliance in October 10, 2023.	ECTIVE Jults will Jenance Je the the honthly mance etting. Jetem wed by ction ed as ure with hts.
K 0363 SS=E Bldg. 01	than required end exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other closures of vertical openings, us areas resist the passage made of 1 3/4 inch e wood or other material ng fire for at least 20 fully sprinklered smoke e only required to resist the e. Corridor doors and doors			

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	OF CORRECTION	IDENTIFICATION NUMBER 155202	A. BUILDING B. WING	01	COMPLETED 09/06/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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	
	hardware. Roller la CMS regulation. T apply to auxiliary s flammable or comic Clearance betwee covering is not excorrectly applied. There is closing of the door release when the copermitted. Nonrate unlimited height an meeting 19.3.6.3.6 frames shall be late other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrictly resistance of glass assemblies. 19.3.6.3, 42 CFR 1483, and 485 Show in REMARK fire protection ratin devices, etc.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Dutch doors are permitted. Door compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments citions in area or fire as or frames in window Parts 403, 418, 460, 482, S details of doors such as ags, automatics closing				
	facility failed to ens corridor doors were suitable for keeping impediment to closi	ation and interview, the ure 1 of 48 resident room provided with a means the door closed, had no ng, latching and would resist the te. This deficient practice imately 2 residents.	K 0363	K363 – It is the intent of the facility to ensure resident roon corridor doors are provided wi means suitable for keeping the door closed, has no impedime closing, latching and will resist passage of smoke and to ensucorridor doors are provided wi means suitable for keeping the	th a e ent to t the ure th a	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED		
	155202	B. WING	09/06/2023		

	155202	B. WING		09/06/2023
NAME OF PROVIDER OR SUPPLIER			Γ ADDRESS, CITY, STATE, ZIP COD	
NAME OF	FROVIDER OR SUFFLIER	1601	HOSPITAL DR	
WATER	S OF GREENCASTLE, THE	GREE	ENCASTLE, IN 46135	
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE		DROWINERS DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOPE)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
			door closed, have no impedime	nts
	Based on observation with the Administrator on		to closing, latching and will resis	
	09/06/23 at 12:50 p.m., the corridor doors to		the passage of smoke to meet s	■
	resident room 126 did not latch into the frame		standards.	
	when tested. Based on interview at the time of		1. CORRECTIVE ACTIONS	
	observation, the Administrator agreed that the		TAKEN:	
	door to resident room 126 did not latch into the		a. On September 7, 2023 th	e
	frame and would need adjusting.		Maintenance Supervisor/design	ee
			repaired the latching mechanisr	
	The finding was reviewed with the Administrator		in the corridor door to resident	
	and the Director of Nursing during the exit		room 126 so it would latch fully	
	conference.		into the frame to meet set	
			standards. The Administrator	
	2. Based on observation and interview, the		verified the repairs on Septemb	er
	facility failed to ensure 1 of over 50 corridor doors		7, 2023.	
	were provided with a means suitable for keeping		b. On September 7, 2023 tl	ne
	the door closed, had no impediment to closing,		Maintenance Supervisor/design	ee
	latching and would resist the passage of smoke.		removed the wedges that were	
	This deficient practice could affect 5 residents,		used to prop open the double	
	staff and visitors in the vicinity of the Therapy		doors serving as the entrance to	
	room.		the Therapy Room to meet set	
			standards. The Administrator	
	Findings include:		verified the work on September	7,
			2023.	
	Based on observation after the entrance to the		2. ALL OTHERS WITH	
	facility on 09/06/23 at 9:30 a.m. the corridor double		POTENTIAL TO BE AFFECTED	D:
	doors serving as the entrance to the Therapy		a. All residents and all staff	
	Room were propped in the fully open position		and visitors have the potential to	
	with rubber wedges at the floor. Based on		be affected but none were. The	
	observation during a tour of the facility at 1:20		Maintenance Supervisor/design	ee
	p.m. with the Administrator and Director of		inspected all corridor doors to	
	Nursing, the corridor double doors serving as		ensure they latch fully into the	.
	entrance to Therapy were propped fully open by		frame and have no obstructions	to
	rubber wedges at the floor. Based on interview at		closing and found no other	
	the time of observation, the Administrator		negative findings.	_
	confirmed the corridor doors were propped in the		3. MEASURES TO PREVEN	''
	fully open position with wedges placed on the		REOCCURRENCE:	
	floor.		a. The Administrator will	
			in-service the new Maintenance	

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This finding was reviewed with the Administrator

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Supervisor/designee and all staff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202		X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPL B. WING 09/06		LETED			
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE		<u> </u>	1601 H	ADDRESS, CITY, STATE, ZIP COD OSPITAL DR NCASTLE, IN 46135	•		
	S OF GREENCAST SUMMARY (EACH DEFICIE) REGULATORY O	DVIDER OR SUPPLIER DF GREENCASTLE, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION and Director of Nursing at the exit conference.		1601 H	OSPITAL DR	e rs and g to ect he nave a essults are essed ne gnee ator	(X5) COMPLETION DATE
					Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction	hly ce J. by	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155202	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/06/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE		1601 H	STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE	
				developed and impleme deemed necessary to er compliance is maintaine. This plan of correction constitutes our credible allegation of compliance all regulatory requirem. Our date of compliance September 7, 2023.	nsure d. e ee with ents.	
K 0918 SS=C Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a program and testing of the switches are performed in 10-second critical and testing of the switches are performed in 10-second critical and testing of the switches are performed in 10-second in 1	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised in this for 4 continuous hours. It is defined to the continuous hours.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155202			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 09/06/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of maintenance ar and readily availal and circuits are m and separate from Minimizing the poseum ergency power consideration for refeat. 4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record reversided to ensure a winspections for the gof 52 weeks. NFPA generators shall be a NFPA 110, Standar Power Systems. NI Emergency Power Sincluding all appurt inspected weekly ar 99, 6.4.4.2 requires performance, exercing generator to be regured for inspection by the jurisdiction. This direstidents, staff and Findings include: Based on record reversided for review time of record review time of record review weekly generator test the aforementioned.	nd testing are maintained ble. EES electrical panels arked, readily identifiable, a normal power circuits. Essibility of damage of the source is a design new installations. (NFPA 99), NFPA 110, D (NFPA 70) which was maintained for 2 to 20, 6.4.4.1.3 requires onsite maintained in accordance with different for a maintained in accordance with different for a maintained in accordance with different for a written record of inspection, issing period, and repairs for the alarly maintained and available and available end at a written record of inspection, issing period, and repairs for the alarly maintained and available end authority having efficient practice could affect all visitors. The weeks of 09/26/22 and negative with the Administrator on a.m. to 12:15 p.m., the weeks of 09/26/22 and negative with the Administrator confirmed sting was not documented on	K 0918	K918 – It is the intent of the facility to ensure a written recof weekly inspections for the generator is maintained for all weeks to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. The Administrator will in-service the new Maintenan Supervisor/designee on September 29, 2023 on the requirement that a weekly tes all 52 weeks must be conduct on the emergency generator is required to meet set standard b. On September 9, 2023 Maintenance Supervisor/designee on September 10, 2023 Maintenance Supervisor/designed to meet set standard the results in the facilities Life Safety Binder to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. 3. MEASURES TO PREVINCE: a. The Maintenance	ord 09/09/2023 ord 152 IS ce t for red s s. the gnee ency ed ED: ff I to ENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED		
155202			B. WING		09/06/2023	
NAME OF I	DROVIDED OD GUDDUIE		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	.K	1601 H	IOSPITAL DR		
WATERS	OF GREENCAST	「LE, THE	GREE	NCASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINED'S BLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	3.1-19(b)			weekly emergency generator te	st	
				is conducted for all 52 weeks ar	nd	
				documented in the life safety		
				binder to meet set standards.		
				b. 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 Maintenan	ce	
				Supervisor/designee to the		
				Administrator monthly and the		
				Administrator will present the		
				inspection results at the monthl	· I	
				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.		
	I		1	an regulatory requirements.	ı	

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Our date of compliance is September 9, 2023.