PRINTED: 08/24/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC				ONIB NO. 0936-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED		
		155223	B. WING		08/08/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(VA) ID	CHMMADY	CTATEMENT OF DEFICIENCIE	ID.	T	(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
E 0000							
Bldg	conducted by the Irraccordance with 42 Survey Date: 08/08 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Waters of Covingto with Emergency Pr Medicare and Medicare and Medicare and Suppliers, 42 C The facility has 119 the survey, the cens	00128 155223 289650 Preparedness survey, The on was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.	E 0000	Preparation and/or execut of this plan of correction in general, or this corrective action in particular, does reconstitute an admission of agreement by this facility of facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepand/or executed in complimitation of correction constitutes a written allegated of substantial compliance federal Medicare and Medicaid requirements.	not r of the ns set  pared ance s.		
K 0000							
Bldg. 01	Licensure Survey w Department of Head 483.70(a).  Survey Date: 08/08  Facility Number: 0 Provider Number: 100  At this Life Safety	000128 155223 289650 Code survey, The Waters of	K 0000	Preparation and/or execut of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepand/or executed in compli	not r of the ns set pared ance		
	Covington was four	nd not in compliance with		with state and federal laws	s.		

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155223		A. BUILDING 01  B. WING		COMPLETED 08/08/2022	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932	
(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
	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation This one-story facility Protect V (000) construction facility has a fire all detection in the corricorridors, and batter in all resident sleepi capacity of 119 and of this visit.  All areas where resident specification in the corricorridors and batter in all resident sleepi capacity of 119 and of this visit.	articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Aty was determined to be of ruction and fully sprinkled. The arm system with smoke idors, spaces open to the ry-operated smoke detectors ng rooms. The facility has a had a census of 90 at the time dents have customary access all areas providing facility cled except for a detached letached Garage which were		This plan of correction constitutes a written allegati of substantial compliance wi Federal Medicare and Medicaid requirements.	
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			

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Event ID:

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CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  08/08/2022
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST IGTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	hazardous areas a REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collectio (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32 Based on observation failed to ensure the hazardous areas, su rooms over 50 square devices which would automatically close or provided with son deficient practice co and 2 visitors.  Findings include:  Based on observation tour of the facility a Administrator, the of across from the Act approximately 30 b measured approximately 30 b measured approximately 30 b measured approximately 30 b measured approximately 30 b	lons) orage Rooms/Spaces eet) classified as Severe	K 0321	K321– It is the intent of the facility to ensure hazardous are such as combustible storage rooms over 50 sq. feet, soiled linen rooms, and boiler rooms provided with self closing device which would cause the doors to automatically close and latch in the door frames or provided wis smoke resistant partitions to me set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 8/9/2022 the Maintenance Supervisor/design installed a self closing device to the door to the Conference rooms to that it self closes and latche fully into the frame to meet set standards. The Administrator	are ces o nto ith neet  s nee

door leading to the corridor. Based on an

verified the work on 8/15/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  08/08/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
(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	
	facility Administrat move all the gloves self-closing device conference room. D the facility Adminis additional informati	e of the observation, the or stated that she would either to another location, or have a added to the door to the ruring the exit conference with strator at 1:55 p.m., no on or evidence could be this deficient finding.		2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all state and visitors have the potential be affected but none were. On 8/9/22 the Maintenance Supervisor/designee inspected hazardous areas for self-closid devices and found no other negative findings.  3. MEASURES TO PREVINGE: a. On 8/15/2022 the Administrator inserviced the Maintenance Supervisor/designenther that all hazardous area doors must have self-closing devices and latch into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly self-closing devices as a part the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designer with the Administration the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	ff I to I to In I d all Ing  ENT  gnee ave fully  ect / for of  sults are essed ne gnee	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

08/24/2022 PRINTED: FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/08/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(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		
				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/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 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 8/15/2022.	vill nce  nly ce . by n		
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric ( National Fire Alam Records of system and testing are re 9.6.1.3, 9.6.1.5, N	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	<b>K345</b> – It is the intent of the fac	cility 08/15/2022		

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failed to maintain the fire alarm system to assure

Event ID:

VUDG21 Facility ID: 000128

K 0345

If continuation sheet

to ensure to maintain the fire

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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 <u>01</u>			COMPLETED	
		155223	B. W	ING		08/08/	2022
		<u> </u>		CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(		THE			LIBERTY ST		
WATERS	S OF COVINGTON	, IHE		COVIN	GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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 O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that it had accurate	time and date information in			alarm system to assure that it	has	
	accordance with the	e requirements of NFPA 101-			an accurate time and date		
	2012 edition, Section	ons 19.3.4 and 9.6 and NFPA 72			information in accordance with	n	
	- 2010 edition, Sec	tions 14.1, 14.1.1. This deficient			NFPA 101-2012 edition, Secti	ons	
	practice could affect all residents, staff, and				19.3.4 and 9.6 and NFPA 72-2	2010	
	visitors in the facili	ity.			edition, Sections 14.1, 14.1.1	to	
					meet set standards.		
	Findings include:				1. CORRECTIVE ACTION	s	
					TAKEN:		
	Based on observati	ons made on 08/08/22 during a			a. On 8/9/2022 a licensed	fire	
	tour of the facility	at 11:25 a.m. with the Facility			alarm contractor/designee		
	Administrator, the	time on the fire alarm control			corrected the time on the fire		
	panel was incorrect	t. The display on the main fire			alarm control panel to meet se	et	
	alarm control panel	indicated the date to be			standards. The Administrator		
	correct, but the tim	e indicated 8:26 a.m. at 11:26			verified the work on 8/15/2022	<u> 2</u> .	
	a.m. Based on inter	view at the time of observation,			2. ALL OTHERS WITH		
	the facility Admini	strator indicated she was			POTENTIAL TO BE AFFECTE	ED:	
	unaware of the disc	repancy and would contact			a. All residents and all sta	ff	
	the alarm company	vendor to have the displayed			and visitors have the potential	to	
	time updated on the	e fire alarm control panel			be affected but none were.		
	immediately.				3. MEASURES TO PREVE	ENT	
	During the exit con	ference with the facility			REOCCURRENCE:		
	Administrator at 1:	55 p.m., no additional			a. On 8/15/2022 the		
	information or evid	lence could be provided			Administrator inserviced the		
	contrary to this def	icient finding.			Maintenance Supervisor/desig	gnee	
					on the requirement that fire al	arm	
	3.1-19(b)				control panel must show corre	ect	
					time of day and date to meet s	set	
					standards.		
					b. Maintenance		
					Supervisor/designee will ensu	re	
					fire alarm control panel shows	;	
					correct time of day and date a	s a	
					part of the facility's Preventive	;	
					Maintenance Program and		
					document those inspection re-	sults	
					as appropriate. If any issues	are	
					discovered, they will be addre	ssed	
					and resolved immediately. Th	ie	
					Maintenance Supervisor/desig	gnee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155223	B. WI	NG		08/08/	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			LIBERTY ST		
WATERS	OF COVINGTON,	THE					
WATERS	or covingion,	1116	COVINGTON, IN 47932		O 1 O 1 1, 11 1 4 1 3 3 2		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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. <b>MONITORING</b>		
					CORRECTIVE ACTION:		
					a. The inspection results w	vill	
					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	by	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	ıs	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	n	
					all regulatory requirements.		
					Our date of compliance is 8/15/2022.		
					0/13/2022.		
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
		er and standpipe systems					
		ted, and maintained in					
	•	IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155223	B. W	NG		08/08/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVINGTON, IN 47932			
	·				1		Т
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	1	n design, maintenance,					
	inspection and testing are maintained in a						
		nd readily available.					
	a) Date sprinkler system last checked						
	h) Who provided	Layotam toot					
	b) Who provided system test						
	c) Water system	supply source					
	oj water system	supply source					
	Provide in RFMAR	RKS information on					
		non-required or partial					
	automatic sprinkler system.						
	9.7.5, 9.7.7, 9.7.8	=					
		view and interview, the facility	K 0	353	K353 – It is the intent of the		09/12/2022
	failed to ensure 1 or	f 1 automatic sprinkler piping			facility to ensure automatic		
	systems was exami	ned for internal obstructions			sprinkler piping systems are		
	where conditions ex	xist that could cause			examined for internal obstruct	ions	
	obstructed piping as	s required by NFPA 25, 2011			where conditions exist that co	uld	
	Edition, the Standar	rds for the Inspection, Testing			cause obstructed piping as		
	and Maintenance of	f Water-Based Fire Protection			required by NFPA 25, 2011		
	Systems, Section 14	4.2.1. Section 14.2.1 states,			Edition, The Standards for the	<u>,</u>	
	"except as discusse	d in 14.2.1.1 and 14.2.1.4 an			Inspection, Testing and		
		g and branch line conditions			Maintenance of Water Based	Fire	
		every 5 years by opening a			Protection Systems, Section		
	1	at the end of one main and by			14.2.1 to meet set standards.		
		er toward the end of one branch					
	l * *.	of inspecting for the presence			1.CORRECTIVE ACTIONS		
	1	and inorganic material. This			TAKEN:		
	_	ffects all residents, staff, and			1.A Certified Sprinkler		
	visitors.				Contractor will perform the interest of the contractor will perform the contractor will be contracted as a contra		
	E' 1' ' 1 1				pipe inspection on the sprinkle		
	Findings include:				system and will be completed	•	
	Dagad or	view on 00/00/22 of 10:41			9/6/2022 to meet set standard		
		view on 08/08/22 at 10:41 a.m.			The Administrator verified the	work	
		dministrator, the Sprinkler			on 9/6/2022.		
	1 -	titled "Sprinkler Report of			2.ALL OTHERS WITH	ED:	
		8/25/21 indicated the last igation was completed on			1.All residents and all sta		
		ate was also verified by a sticker					
		tler system riser. Based on an			and visitors have the potential be affected but none were.	. 10	
	Praced in the sprink	aci system niser. Daseu on an			pe anecieu bul none were.		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155223	B. W	ING		08/08/2022	
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R					
WATERS	S OF COVINGTON	THE	1600 E LIBERTY ST COVINGTON, IN 47932				
WATERC		, 1111		COVIIN			
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TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		facility Administrator at the			3.MEASURES TO PREVEN	Т	
		ew, she stated that upon his			REOCCURRENCE:		
		ance Director would get the			1.On 8/15/2022 the		
		igation scheduled with the			Administrator inserviced the		
	vendor. During the exit conference with the				Maintenance Supervisor/desig	jnee	
		tor at 1:55 p.m., no additional			on the requirement that the		
		lence could be provided			sprinkler system must be prop	-	
	contrary to this deficient finding.				maintained to meet set standa	ırds.	
	3.1-19(b)				2.Maintenance		
	3.1-19(b)				Supervisor/designee will ensu	re	
					the internal pipe inspection is		
					performed on the sprinkler sys	stem	
					every 5 years as a part of the		
					facility's Preventive Maintenar		
					Program and document those		
					inspection results as appropri		
					If any issues are discovered, t	-	
					will be addressed and resolve		
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					with the Administrator the		
					inspection results.		
					3.The Administrator w	/III	
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					1.MONITORING CORRECTIVE ACTION:		
					1.The inspection resu	lte	
					will be presented by the	ii3	
					Maintenance Supervisor/design	nnee	
					to the Administrator monthly a	•	
					the Administrator will present		
					inspection results at the month		
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed		
	I		1		I sombonomo will be reviewed	~ y	I

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CENTERS FO	R MEDICARE & MEDIC				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/08/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
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				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 9/12/2022.	s	
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 or in the facility were NFPA 10, Standard 2010 Edition. Section extinguishers shall where they will be a immediately availal Preferable they shall paths of travel, includeficient practice or residents, 4 staff and Findings include:	nguishers guishers are selected, d, and maintained in MFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility f 26 portable fire extinguishers installed in accordance with for Portable Fire Extinguishers, on 1-6.3 states Fire be conspicuously located readily accessible and ole in the event of a fire. Il be located along normal uding exits from areas. This ould affect as many as 16 d 2 visitors.	K 0355	K355– It is the intent of the facto ensure portable fire extinguishers in the facility are installed in accordance with Ni 10 to meet set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 8/5/2022 Maintenand Supervisor/designee removed Hoyer lift that was blocking the extinguisher located near resignom #29 to meet set standard The Administrator verified the on 8/15/2022.  2. ALL OTHERS WITH	FPA  S  ce the e fire dent ds. work	
	tour of the facility a	ons made on 08/08/22 during a tt 11:22 a.m. with the Facility  ABC portable fire extinguisher		a. All residents and all staf	f	

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located near resident room #29 was obstructed by

a Hoyer lift. Based on interview at the time of

Event ID:

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be affected but none were. On

8/15/2022 the Maintenance

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155223	B. WING		08/08/2022	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	,	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110	observation, the fac		1110	Supervisor/designee inspecte		
		ire extinguisher located in the		fire extinguishers throughout t		
		bstructed, and not readily		facility and found no other neg		
		ed the Hoyer lift to another		findings.	jauve	
		he deficiency This deficiency		3. MEASURES TO PREVE	ENIT	
	_	-			-IN I	
	was removed prior	to my exiting the facility.		REOCCURRENCE:		
	2.1.10/1->			a. On 8/26/2022 the		
	3.1-19(b)			Administrator inserviced the		
				Maintenance Supervisor/desig	nee	
				& all other staff on the		
				requirement that fire extinguis		
				must be installed in accordance		
				with the requirements of NFP	A 10,	
				1-6.3 to meet set standards.		
				b. Maintenance		
				Supervisor/designee will inspe		
				all fire extinguishers througho		
				the facility weekly to ensure th	iey	
				are not blocked and are in		
				accordance with the NFPA		
				requirements as a part of the		
				facility's Preventive Maintenar		
				Program and document those		
				inspection results as appropri	•	
				If any issues are discovered, t	•	
				will be addressed and resolve		
				immediately. The Maintenand	•	
				Supervisor/designee will revie	w	
				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. 1.		
				MONITORING CORRECTIVE		
				ACTION:		
				a The inspection results v	vill	

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be presented by the Maintenance

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	R MEDICARE & MEDIC						IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	A. BU	) MULTIPLE CONSTRUCTION (X3) DATE  BUILDING 01 COMPL  WING 08/08/		LETED	
	PROVIDER OR SUPPLIER			1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie	ilding Spaces - Smoke ilding Spaces - Smoke			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 developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 8/26/2022.	hly ce g. by n as	
	Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that r Nonrated protectiv are permitted. Do fixed fire window a are self-closing or	arriers are 1-3/4-inch thick					

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in the direction of egress travel. Door opening provides a minimum clear width of 32 inches

Based on observation and interview, the facility

failed to ensure 1 of 10 sets of barrier doors would

for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9

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K 0374

If continuation sheet

K374 - It is the intent of the

facility to ensure smoke barrier

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08/09/2022

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155223		155223	B. WING 08/08/2			08/08/20	22
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(		THE			LIBERTY ST		
WATERS	S OF COVINGTON	INE		COVIN	GTON, IN 47932		
(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 C	OMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	restrict the moveme	ent of smoke for at least 20			doors would restrict the move	ment	
	minutes. LSC, Sect	ion 19.3.7.8 requires that doors			of smoke for at least 20 minute	es	
	in smoke barriers s	hall comply with LSC, Section			to meet set standards.		
	8.5.4. LSC, Section	n 8.5.4.1 requires doors in smoke					
	barriers to close the	e opening leaving only the			1. CORRECTIVE ACTIONS		
	minimum clearance	e necessary for proper operation			TAKEN:		
	which is defined as	1/8 inch to restrict the			a. On 8/8/2022 Maintenan	ce	
	movement of smok	e. This deficient practice			Supervisor/designee repaired	the	
	affects 18 residents	, as well as 4 staff and 2			set of smoke barrier doors, to		
	visitors.				restrict the movement of smok	e for	
					at least 20 minutes, nearest to	the	
	Findings include:				ICF coordinators office to ensi		
	T manage merade.				they self-close & fully latch into	, l	
	Based on observati	ons made on 08/08/22 during a			frame to meet set standards.		
	tour of the facility at 11:28 a.m. and again at 12:18				b. On 8/9/2022 Maintenar	ice	
	p.m. with the Facility Administrator, the following				Supervisor/designee repaired	the	
	sets of barrier doors failed to fully close:				set of smoke barrier doors, to		
	a) the barrier door set nearest to the I.C.F.				restrict the movement of smok	e for	
	coordinators office failed to fully close smoke				at least 20 minutes, on the sk	illed	
	tight leaving a five-inch gap when closed to their				South unit to ensure they		
	fullest.				self-close & fully latch into fran	ne	
	b) the barrier door set on the Skilled South unit				to meet set standards.		
	failed to fully close smoke tight leaving a four-				2. ALL OTHERS WITH		
	inch gap when closed to their fullest.				POTENTIAL TO BE AFFECTE	D:	
	Based an interview at the time of each				a. All residents and all stat	f	
	aforementioned observation, the facility				and visitors have the potential	to	
	Administrator stated that she would have the				be affected but none were. O		
	Maintenance Director address these doors upon				8/9/2022 the Maintenance		
	his return to work at the facility. During the exit				Supervisor/designee inspected	d all	
	conference with the facility Administrator at 1:55				smoke barrier doors to ensure		
	p.m., no additional information or evidence could		they self-close and fully latch into		nto		
	be provided contrary to this deficient finding.				frame and found no other neg	ative	
					findings.		
	3.1-19(b)				3. MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a. On 8/15/2022 the		
					Administrator/designee inserv	ced	
					the Maintenance		
					Supervisor/designee on the		
					requirement that smoke barrie	r	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155223		A. BUILDING  B. WING	01	COMPLETED 08/08/2022				
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(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)	DATE			
				doors must self-close and fully latch into frame and restrict the movement of smoke for at least minutes to meet set standards b. Maintenance Supervisor/designee will test a smoke barrier doors throughout the facility monthly to ensure the self-close and fully latch into the frame as a part of the facility's Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they will addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.  c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. MONITORING CORRECTIVE ACTION:  a. The inspection results where the month of the Administrator will present the inspection results at the month of 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 and implem	e st 20 st 20 st.  all ut hey ne ram n ll be e w w w w w w w w w w w w w w w w w			

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and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between

9:00 PM and 6:00 AM, a coded

19.7.1.4 through 19.7.1.7

audible alarms.

and residents.

Findings include:

announcement may be used instead of

Based on record review and interview, the facility

failed to conduct quarterly fire drills for 2 of 4

conducted quarterly on each shift under varied

conditions. This deficient practice affects all staff

Based on record review of the "Fire Drill Report"

9:48 a.m., there was no documentation for a third

February, or March) of 2022. Additionally, there

was no documentation for a third shift fire drill in

the second quarter (April, May, or June) of 2022

shift fire drill in the first quarter (January,

form with the facility Administrator on 08/08/22 at

quarters. LSC 19.7.1.6 requires drills to be

DED A DTMENT	OF HEALTH AND HUN	AAN CEDVICEC				PRIN		08/24/2022 PROVED
	MEDICARE & MEDICA						B NO. 0	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/08/2022		
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(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)	TE	COMF	(X5) PLETION ATE
K 0712 SS=F Bldg. 01	alarm signal and s	he transmission of a fire imulation of emergency fire			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 8/9/2022.	1		

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K 0712

Facility ID: 000128

standards.

K712 - It is the intent of the

facility to ensure to conduct

set standards.

1.

TAKEN:

quarterly fire drills on each shift

under varied conditions to meet

On 8/9/2022 the Administrator inserviced the

Maintenance Supervisor/designee

must be conducted at unexpected

times under varying conditions at

least quarterly on each shift and

documented to meet set

on the requirement that fire drills

**CORRECTIVE ACTIONS** 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 08/08/2022						
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE				
	review, the facility the aforementioned that the Maintenanchis desk or in anoth could not be located this survey. During facility Administrat	erview at the time of record Administrator acknowledged missing fore drills and stated e Director may have them on er location, but that they I for review as of the time of the exit conference with the or at 1:55 p.m., no additional ence could be provided cient finding.		2. ALL OTHERS WITH POTENTIAL TO BE AFFECTI a. All residents and all sta and visitors have the potential be affected but none were. 3. MEASURES TO PREVI REOCCURRENCE: a. Maintenance Supervisor/designee will ensu- fire drills are conducted at unexpected times under varyi conditions at least quarterly or each shift and documented or Fire Drill Report and that documentation be retained in facility's Life Safety Binder as part of the facility's Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrate the inspection results. 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 we be presented by the Maintenance supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan	ff to  ENT  re  ng n the the a sults are ssed he gnee ttor  vill nce			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/08/2022		
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIA		ΓE	DATE
					Improvement (QA/PI) meeting Inspection results and system components will be reviewed to 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 8/9/2022.	oy n as	

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