STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155223	A. BUILDING -- B. WING	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/08/22 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 At this Emergency Preparedness survey, The Waters of Covington was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 119 certified beds. At the time of the survey, the census was 90. Quality Review completed on 08/09/22	E 0000	**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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/08/22 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 At this Life Safety Code survey, The Waters of Covington was found not in compliance with	K 0000	**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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 90 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for a detached storage shed and a detached Garage which were not sprinklered. Quality Review completed on 08/09/22		**This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 8 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect 18 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 08/08/22 during a tour of the facility at 11:40 a.m. with the Facility Administrator, the Conference room located across from the Activities room contained approximately 30 boxes of gloves. This room measured approximately 360 square feet (16 X 16) in size and also lacked a self-closing device on the door leading to the corridor. Based on an	K 0321	**K321**– It is the intent of the facility to ensure hazardous areas, such as combustible storage rooms over 50 sq. feet, soiled linen rooms, and boiler rooms are provided with self closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 8/9/2022 the Maintenance Supervisor/designee installed a self closing device to the door to the Conference room so that it self closes and latches fully into the frame to meet set standards. The Administrator verified the work on 8/15/2022	08/15/2022

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	interview at the time of the observation, the facility Administrator stated that she would either move all the gloves to another location, or have a self-closing device added to the door to the conference room. During the exit conference with the facility Administrator at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 8/9/22 the Maintenance Supervisor/designee inspected all hazardous areas for self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 8/15/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous area doors must have self-closing devices and latch fully into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly for self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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			documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/15/2022.**	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure	K 0345	**K345**– It is the intent of the facility to ensure to maintain the fire	08/15/2022

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	that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made on 08/08/22 during a tour of the facility at 11:25 a.m. with the Facility Administrator, the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date to be correct, but the time indicated 8:26 a.m. at 11:26 a.m. Based on interview at the time of observation, the facility Administrator indicated she was unaware of the discrepancy and would contact the alarm company vendor to have the displayed time updated on the fire alarm control panel immediately. During the exit conference with the facility Administrator at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		alarm system to assure that it has an accurate time and date information in accordance with NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72-2010 edition, Sections 14.1, 14.1.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 8/9/2022 a licensed fire alarm contractor/designee corrected the time on the fire alarm control panel to meet set standards. The Administrator verified the work on 8/15/2022. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 8/15/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire alarm control panel must show correct time of day and date to meet set standards. b. Maintenance Supervisor/designee will ensure fire alarm control panel shows correct time of day and date as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee	

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			will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/15/2022.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff, and visitors. Findings include: Based on record review on 08/08/22 at 10:41 a.m. with the Facility Administrator, the Sprinkler Systems document titled "Sprinkler Report of Inspection" dated 08/25/21 indicated the last internal pipe investigation was completed on 05/17/2017. This date was also verified by a sticker placed in the sprinkler system riser. Based on an	K 0353	**K353** – It is the intent of the facility to ensure automatic sprinkler piping systems are examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, The Standards for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, Section 14.2.1 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.A Certified Sprinkler Contractor will perform the internal pipe inspection on the sprinkler system and will be completed by 9/6/2022 to meet set standards. The Administrator verified the work on 9/6/2022. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were.	09/12/2022

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	interview with the facility Administrator at the time of record review, she stated that upon his return, the Maintenance Director would get the internal pipe investigation scheduled with the vendor. During the exit conference with the facility Administrator at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 8/15/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the internal pipe inspection is performed on the sprinkler system every 5 years as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **1.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by	

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			the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/12/2022.**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice could affect as many as 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 08/08/22 during a tour of the facility at 11:22 a.m. with the Facility Administrator, the ABC portable fire extinguisher located near resident room #29 was obstructed by a Hoyer lift. Based on interview at the time of	K 0355	**K355**– It is the intent of the facility to ensure portable fire extinguishers in the facility are installed in accordance with NFPA 10 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 8/5/2022 Maintenance Supervisor/designee removed the Hoyer lift that was blocking the fire extinguisher located near resident room #29 to meet set standards. The Administrator verified the work on 8/15/2022 . **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 8/15/2022 the Maintenance	08/26/2022

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	observation, the facility Administrator acknowledged the fire extinguisher located in the laundry room was obstructed, and not readily accessible and moved the Hoyer lift to another location removing the deficiency This deficiency was removed prior to my exiting the facility. 3.1-19(b)		Supervisor/designee inspected all fire extinguishers throughout the facility and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 8/26/2022 the Administrator inserviced the Maintenance Supervisor/designee & all other staff on the requirement that fire extinguishers must be installed in accordance with the requirements of NFPA 10, 1-6.3 to meet set standards. b. Maintenance Supervisor/designee will inspect all fire extinguishers throughout the facility weekly to ensure they are not blocked and are in accordance with the NFPA requirements as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **1. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

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			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/26/2022.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 10 sets of barrier doors would	K 0374	**K374** – It is the intent of the facility to ensure smoke barrier	08/09/2022

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	restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 18 residents, as well as 4 staff and 2 visitors. Findings include: Based on observations made on 08/08/22 during a tour of the facility at 11:28 a.m. and again at 12:18 p.m. with the Facility Administrator, the following sets of barrier doors failed to fully close: a) the barrier door set nearest to the I.C.F. coordinators office failed to fully close smoke tight leaving a five-inch gap when closed to their fullest. b) the barrier door set on the Skilled South unit failed to fully close smoke tight leaving a four-inch gap when closed to their fullest. Based an interview at the time of each aforementioned observation, the facility Administrator stated that she would have the Maintenance Director address these doors upon his return to work at the facility. During the exit conference with the facility Administrator at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		doors would restrict the movement of smoke for at least 20 minutes to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 8/8/2022 Maintenance Supervisor/designee repaired the set of smoke barrier doors, to restrict the movement of smoke for at least 20 minutes, nearest to the ICF coordinators office to ensure they self-close & fully latch into frame to meet set standards. b. On 8/9/2022 Maintenance Supervisor/designee repaired the set of smoke barrier doors, to restrict the movement of smoke for at least 20 minutes, on the skilled South unit to ensure they self-close & fully latch into frame to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 8/9/2022 the Maintenance Supervisor/designee inspected all smoke barrier doors to ensure they self-close and fully latch into frame and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 8/15/2022 the Administrator/designee inserviced the Maintenance Supervisor/designee on the requirement that smoke barrier	

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	155223	A. BUILDING 01 B. WING	08/08/2022

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			doors must self-close and fully latch into frame and restrict the movement of smoke for at least 20 minutes to meet set standards. b. Maintenance Supervisor/designee will test all smoke barrier doors throughout the facility monthly to ensure they self-close and fully latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as	

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			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.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected 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 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" form with the facility Administrator on 08/08/22 at 9:48 a.m., there was no documentation for a third shift fire drill in the first quarter (January, 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	K 0712	**K712** – It is the intent of the facility to ensure to conduct quarterly fire drills on each shift under varied conditions to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 8/9/2022 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards.	08/09/2022

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	either. Based on interview at the time of record review, the facility Administrator acknowledged the aforementioned missing fore drills and stated that the Maintenance Director may have them on his desk or in another location, but that they could not be located for review as of the time of this survey. During the exit conference with the facility Administrator at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 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 Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/9/2022.**	