DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		JILDING	ONSTRUCTION	(X3) DATE COMPL 10/02/	ETED	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(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)	TE	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/2/23 Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140 At this Emergency Preparedness survey, The Waters of Middletown Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 23. Quality Review completed on 10/06/23		E 0	E 0000 DISCLAIMER STATEMEN Preparation and/or execu of this plan of correction general, or this corrective action, does not constitut admission or agreement I facility of the facts allege conclusions set forth in ti statement of deficiencies plan of correction and sp corrective actions are pre and/or executed in compl with state and federal law This plan of correction constitutes a written alleg of substantial compliance Federal Medicare and Medicaid requirements. Request paper compliance		n his r he fic red ce	
K 0000							,
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/2/ Facility Number: 0 Provider Number: AIM Number: 1000	00342 155573	FR		DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. Ti plan of correction and specifi corrective actions are prepart and/or executed in complian	n his r he fic red	
LADODATOD	V DIDECTORIC OR BROX	VIDER/SUPPLIER REPRESENTATIVE'S SI	CNIATIID	Г	TITI F		(X6) DATE

(X6) DATE

Roberta Scott Shull 10/19/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		A. B	MULTIPLE CO UILDING /ING	onstruction 01	(X3) DATE COMPI 10/02		
WATERS	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	ТНЕ	981 BEI	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) TAG			(X5) COMPLETION DATE
	not in compliance w Participation in Med Subpart 483.90(a), 3 2012 edition of the Association (NFPA	Nursing Facility was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and			with state and federal laws This plan of correction constitutes a written allega of substantial compliance Federal Medicare and Medicaid requirements. Request paper compliance	ation with	
	Type V (000) const The facility has a findetection in the corricorridors, and batter all resident sleeping	ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the ry operated smoke detectors in grooms. The facility has a nad a census of 23 at the time					
	were sprinkled and services were sprinl detached wooden st sprinkled.	dents have customary access all areas providing facility cled. The facility had a orage building which was not					
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the tic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155573	B. W	ING		10/02/	/2023
NAME OF B	AD CLUBED OD CLUBELIED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C		981 BEI	ECHWOOD AVE		
WATERS	OF MIDDLETOWN	N SKILLED NURSING FACILITY, T	HE.	MIDDLE	ETOWN, IN 47356		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
TAG		applied protective plates that		TAU			DATE
	do not exceed 48 inches from the bottom of						
	the door.						
	Describe the floor	and zone locations of					
	hazardous areas t	that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	•					
	•	-Fired Heater Rooms					
	b. Laundries (large	er than 100 square feet)					
	c. Repair, Mainten	nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	classified as Severe					
	Hazard - see K32						
		on and interview, the facility	K 0	321	K321- It is the intent of the fac	cility	10/25/2023
		f over 10 hazardous area doors,			to ensure hazardous area doc	-	
	such as storage roor	ms, were provided with			such as storage rooms, are		
		elf-closing devices. This			provided with properly working	3	
	•	ould affect more than 6 staff			self-closing devices to meet se	et	
	and visitors near the	e kitchen.			standards.	_	
	Findings include:				1 CORRECTIVE ACTIONS	5	
	rmanigs include:				TAKEN : a On 10/2/2023 the		
	Based on observation	ons and interview during a			Maintenance Supervisor/desig	nee	
		with the Administrator and			repaired the self-closer on the		
	_	nance on 10/02/23 between			kitchen storage room door lea		
	12:30 p.m. and 1:45	5 p.m., the kitchen storage room			into the kitchen to ensure it	-	
		e kitchen, greater than 50			self-closes and latches into the		
		ed a number of combustible			door frame to meet set standa		
		er, plastic, and cardboard			The Administrator verified the	work	
		as equipped with a self-closing			on 10/13/2023.		
		self-close and latch into the			2 ALL OTHERS WITH	ED.	
	door frame.				POTENTIAL TO BE AFFECTE	: υ:	l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIER S OF MIDDLETOWI	R N SKILLED NURSING FACILITY, T	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356	
(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
	The finding was rev Maintenance at the	viewed with the Director of time of discovery and again Ference with the Administrator		a All residents and all staff and visitors have the potential be affected but none were. Or 10/2/2023, the Maintenance Supervisor/designee inspected hazardous area doors for self-closures and found no oth negative findings. 3 MEASURES TO PREVE REOCCURRENCE: a On 10/18/23 the Administrator in-service the Maintenance Supervisor and dietary staff on the requiremer ensure there are no combustit storage items beyond the 50 square feet to meet set standab Maintenance Supervisor/designee will inspeall hazardous areas to ensure doors to hazardous areas are equipped with a self-closure a latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be address and resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results. C The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING	to n d all her NT ht to ble ards. ect nd of sults are sseed he gnee

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CORRECTIVE ACTION:

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	AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLET B. WING 10/02/20			ETED	
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY, T	HE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(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	(X5) COMPLETION DATE
V 0E 11	NEDA 404				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 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 10/25/2023.	nce hly ce by	
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation of 1 electrical juntarintained in a safe 19.5.1.1 requires util LSC 9.1.2 requires to comply with NFF NFPA 70, 2011 Edit	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0	511	K511 – It is the intent of the facility to ensure electrical jund boxes in the attic are maintain in a safe and operating conditi to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 10/23/23 the	ed ion	10/25/2023

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10/25/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/02/2023 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE compatible with the box and suitable for the Maintenance Supervisor/designee conditions of use. Where used, metal covers shall will secured the wires inside the comply with the grounding requirements of electrical box including putting a 250.110. This deficient practice could affect staff cover plate on the electrical box in and 15 residents. the attic space near the front entrance to meet set Findings include: standards **ALL OTHERS WITH** Based on observations and interview during a POTENTIAL TO BE AFFECTED: tour of the facility with the Administrator and All residents and all staff Director of Maintenance on 10/02/23 between and visitors have the potential to 12:30 p.m. and 1:45 p.m., an electrical junction box be affected but none were. in the attic space near the front entrance had **MEASURES TO PREVENT** exposed electrical wiring hanging out of the box. REOCCURRENCE: Based on interview at the time of the observation, On 10/18/23 the the Director of Maintenance acknowledged the Administrator in-service the electrical junction box had 5 wires coming out of Maintenance Supervisor/designee each side of the box and were held together with on the requirement to secure all wire nuts. It was unclear to this surveyor and The wires within the electrical and to DOM was unsure what the wires were servicing. ensure there is a cover on the electrical box and to not have The finding was reviewed with the Director of exposed wires hanging out of the Maintenance at the time of discovery and again junction box to meet set during the exit conference with the Administrator standards. and Director of Maintenance present. The Maintenance Supervisor/designee will ensure to 3.1-19(b) secure all wires within the covered electrical box and to not have exposed wires hanging out of the electrical box and will as a part of the facility's monthly Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.

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The Administrator will monitor adherence to the

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	A. B	MULTIPLE CO UILDING /ING	onstruction 01	(X3) DATE COMPL 10/02/	ETED
	ROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVACTION: a. The inspection results wipresented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator present the inspection results the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented 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 10/25/2023.	Il be e r will at the by	
K 0741 SS=F Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib						

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155573	B. W	NG		10/02	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ECHWOOD AVE		
WATERS	S OF MIDDLETOWI	N SKILLED NURSING FACILITY,	THE		ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	n area shall be posted with					
	_	O SMOKING or shall be					
	I -	ternational symbol for no					
	smoking.						
	1 ' '	occupancies where					
	smoking is prohib						
	1 .	d at all major entrances,					
		vith language that prohibits					
	smoking shall not						
	. ,	atients classified as not					
	responsible shall	·					
		ent of 18.7.4(3) shall not					
	1	atient is under direct					
	supervision.						
	1 ' '	ncombustible material and					
	_	be provided in all areas					
	where smoking is	ers with self-closing cover					
	1 ' '	n ashtrays can be emptied					
		rashinays can be emplied railable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4	icu.					
		on, records review, and	$ _{K0}$	7/1	K741 – It is the intent of the		10/25/2023
		ty failed enforce 1 of 1	IX 0	/ 11	facility to ensure to enforce		10/23/2023
		es. This deficient practice			nonsmoking facilities to meet	set	
	could affect everyo	_			standards.		
	1				1 CORRECTIVE ACTIONS	3	
	Findings include:				TAKEN:		
					a On 10/6/2023 the		
	Based on observation	ons and interview during a			Maintenance		
	tour of the facility v	with the Administrator and			Supervisor/Housekeeping		
	Director of Mainter	nance on 10/02/23 between			Supervisor/designee picked u	p the	
	12:30 p.m. and 1:45	5 p.m., smoking on the property			cigarette butts disposed on the		
	was evident due to	at least 30 cigarette butts on			ground near the facility's diese		
	the ground near the	facility's diesel fired			fired generator to meet set		
	generator. Based or	n interview the Administrator			standards. The Administrator		
	stated smoking is no	ot allowed on the facility's			verified the work on 10/13/202	23.	
	property, staff are a	llowed to smoke only in their			b On 10/20/23 the		

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personal vehicles per the facility's smoking policy.

The finding was reviewed with the Director of

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Administrator in-service all staff on

the requirement that smoking is

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETE	D
		155573	B. W	NG		10/02/202	23
				CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF MIDDLETOWN	ALOKULED MUDOINO EAGULEV. T			ECHWOOD AVE		
WATERS	OF MIDDLE FOW	N SKILLED NURSING FACILITY, T	HE	MIDDLE	ETOWN, IN 47356		
(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 CO	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' <u> </u>	DATE
	Maintenance at the	time of discovery and again			only allowed in the designated		
	during the exit conference with the Administrator				areas and all smoking materia	ls	
	and Director of Maintenance present.				will be disposed of properly to		
					meet set standards.		
	3.1-19(b)				2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTE	D:	
					a All residents and all staft	:	
					and visitors have the potential	to	
					be affected but none were.		
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a Maintenance		
					Supervisor/designee and		
					Housekeeping		
					Supervisor/designee will inspe	ect	
					the grounds of the facility to		
					ensure cigarette butts are not		
					present on the ground and tha	t all	
					employees are smoking only i	n	
					the designated areas and		
					disposing cigarettes in proper		
					containers as appropriate. If	any	
					issues are discovered, they wi	ll be	
					addressed and resolved		
					immediately. The Maintenand	e	
					Supervisor/designee will revie	w	
					with the Administrator the		
					inspection results.		
					b The Administrator will		
					monitor adherence to the Smo	king	
					Policy.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	-	
					Quality Assurance/Performand	ce	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155573 B. WING 10/02/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 10/25/2023. K 0761 SS=F Bldg. 01 K 0761 Based on observation, records review, and K761 - It is the intent of the 10/25/2023 interview, the facility failed to ensure annual facility to ensure annual inspection inspection and testing of fire door assemblies and testing of all fire door were completed in accordance of LSC 19.1.1.4.1.1 assemblies are completed in communicating openings in dividing fire barriers accordance with LSC 19.1.1.4.1.1 required by 19.1.1.4.1 shall be permitted only in communicating openings in corridors and shall be protected by approved dividing fire barriers required by self-closing fire door assemblies. (See also Section 19.1.1.4.1 shall be protected by 8.3.) LSC 8.3.3.1 Openings required to have a fire approved self-closing fire door protection rating by Table 8.3.4.2 shall be assemblies to meet set protected by approved, listed, labeled fire door standards. assemblies and fire window assemblies and their **CORRECTIVE ACTIONS** accompanying hardware, including all frames, TAKEN: closing devices, anchorage, and sills in On 10/5/2023 the accordance with the requirements of NFPA 80, Maintenance Supervisor/designee Standard for Fire Doors and Other Opening conducted the annual inspection Protectives, except as otherwise specified in this of the fire door assembly and Code. NFPA 80 5.2.1 states fire door assemblies documented the inspection results

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shall be inspected and tested not less than

annually, and a written record of the inspection

AHJ. NFPA 80, 5.2.4.1 states fire door assemblies

shall be signed and kept for inspection by the

Event ID:

WHCE21

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on the Annual Door Inspections

log in the Life Safety Binder to

meet set standards. The

Administrator verified the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155573	B. W	ING		10/02/	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ECHWOOD AVE		
WATERS	S OF MIDDLETOWN	N SKILLED NURSING FACILITY, 1	ΓHF		ETOWN, IN 47356		
		TOTALEED HOROMOT HOLETT,		WIIDDL	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	· ·	spected from both sides to			inspection and documentation	on	
	assess the overall condition of door assembly.				10/16/2023.		
	NFPA 80, 5.2.4.2 states as a minimum, the				2 ALL OTHERS WITH		
	following items sha				POTENTIAL TO BE AFFECTE		
	(1) No open holes or breaks exist in surfaces of				a All residents and all staff		
	either the door or frame. (2) Glazing, vision light frames, and glazing beads				and visitors have the potential	το	
					be affected but none were.	NT	
	equipped.	ely fastened in place, if so			3 MEASURES TO PREVE	NI	
		e, hinges, hardware, and			REOCCURRENCE:		
					a On 10/18/2023 the Administrator/Regional Proper	-t. ,	
	noncombustible threshold are secured, aligned,					ιy	
	and in working order with no visible signs of				Manager in-service the	inoo	
	damage. (4) No parts are missing or broken.				Maintenance Supervisor/design on the requirement that annual		
	(4) No parts are missing or broken.(5) Door clearances do not exceed clearances				testing & inspections of fire do		
	listed in 4.8.4 and 6				assemblies must be conducted		
		device is operational; that is,			and documented on the Annua		
		apletely closes when operated			Door Inspections log in the Life		
	from the full open p				Safety Binder to meet set	C	
		is installed, the inactive leaf			standards.		
	closes before the ac				b Maintenance		
		are operates and secures the			Supervisor/designee will ensu	re to	
	door when it is in the	-			conduct the annual inspection		
		vare items that interfere or			fire door assemblies and	0.	
		are not installed on the door or			document those inspection res	sults	
	frame.				in the Life Safety Binder as		
	(10) No field modif	fications to the door assembly			appropriate to meet set		
	` ′	ed that void the label.			standards. If any issues are		
	_	edge seals, where required, are			discovered, they will be addre	ssed	
	inspected to verify	their presence and integrity.			and resolved immediately. Th		
	This deficient pract	ice could affect all residents.			Maintenance Supervisor/desig	nee	
					will review with the Administra	tor	
	Findings include:				the inspection results.		
					c The Administrator will		
	Based on record rev	view, observation and			monitor adherence to the		
	interview with the	Administrator and Director of			Preventative Maintenance		
	Maintenance on 10	/02/23 between 9:50 a.m. and			schedule and validate the		
	_	imentation of a current annual			Preventative Maintenance		
		re door assemblies was			documentation is in place.		
	available for review	v. The most recent			4 MONITORING		

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIER	N SKILLED NURSING FACILITY,	THE	981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	documentation was tour several fire doc corridors and at the The finding was rev Maintenance at the	dated 08/25/22. During the ors were observed in the oxygen transfilling room. viewed with the Director of time of discovery and again erence with the Administrator intenance present.		TAG	CORRECTIVE ACTION: a The inspection results will be presented by the Maintenar 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 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 10/25/2023.	nce ally ce cy n s	DATE
K 0911 SS=E Bldg. 01	Chapter 6 Electric that are not addre K-Tags, but are do along with the app NFPA standard ciron Form CMS-256 Chapter 6 (NFPA Based on observation failed to ensure accommaintained in encloapparatus in 1 of 2 magnetic failed to 2 maintained in 1 of 2 magnetic failed to 2 maintained in 1 of 2 magnetic failed to 2 maintained in 1 of 2 magnetic failed to 2 maintained in 1 of 2 magnetic failed to 2 maintained in 1 of 2 magnetic failed to 2 magnetic fai	s - Other RKS section any NFPA 99 cal Systems requirements ssed by the provided eficient. This information, blicable Life Safety Code or tation, should be included	K 0	911	K911 - It is the intent of the facto ensure access and working space is maintained in enclosure housing electrical apparatus in maintenance offices to meet se	ıres	10/25/2023

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6.3.2.1 states electrical installation shall be in

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standards.

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155573	B. W	NG		10/02/	2023
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			ECHWOOD AVE		
\M/ATEDS	COE MIDDLETOWN	N SKILLED NILIDSING EACH ITV					
WATERS	OF MIDDLE TOWN	N SKILLED NURSING FACILITY, 1	I ПE	MIDDLI	ETOWN, IN 47356		
(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-REFERENCE TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		FPA 70, National Electric Code.			1 CORRECTIVE ACTIONS	3	
	· · ·	ition, Article 110.26 states			TAKEN:		
	working space for equipment operating at 600				a On 10/4/2023 the		
	volts, nominal, or less and likely to require				Maintenance Supervisor/desig		
	examination, adjustment, servicing, or				removed the items stored in fr		
	maintenance while energized shall comply with the				of the main fire alarm control p		
	dimensions of $110.26(A)(1)$, (2) and (3). Distances				and several other electrical se		
	shall be measured from the live parts if such parts				breaker boxes in the Mechani		
	are exposed or from the enclosure front or				Room to meet set standards.		
		enclosed. Article 110.26(B)			Administrator verified removal	of	
	states the working space required by this section				the items on 10/16/2023.		
	shall not be used for storage. This deficient				2 ALL OTHERS WITH	_	
	practice could affect over 10 residents, staff and				POTENTAL TO BE AFFECTE		
	visitors in the 300 Hall.				a All residents and all staft		
	TO 11 1 1 1				and visitors have the potential		
	Findings include:				be affected but none were. O	n	
					10/6/2023 the Maintenance		
		ons and interview during a			Supervisor/designee inspecte		
		with the Administrator and			other areas and found no othe	er	
		nance on 10/02/23 between			negative findings.		
	-	5 p.m., the Mechanical room			3 MEASURES TO PREVE	NT	
		ties main Fire Alarm Control			REOCCURRENCE:		
	_	veral electrical service breaker			a On 10/18/2023 the		
		entioned utilities and FACP			Administrator in-service the		
		ith carts, boxes and debris			Maintenance Supervisor/desig	gnee	
		accessibility to the utility			and all other staff on the		
	•	The Director of Maintenance			requirement that nothing is to		
		an up the area and maintains			impede access to workspaces		
	space around the ut	ilities and FACP.			including fire alarm control par	nel	
	TE1 (* 1'	' 1 '4 4 D' 4 C			and other electrical service		
	_	viewed with the Director of			breaker boxes to meet set		
		time of discovery and again			standards.		
		ference with the Administrator			b Maintenance	4	
	and Director of Mai	intenance present.			Supervisor/designee will inspe		
	2 1 10(1)				all workplaces including the fir	е	
	3.1-19(b)				alarm control panel and other	4-	
					electrical service breaker boxe	es to	
					ensure nothing is impeding	_	
					access to the workspaces as	а	
	l		1		part of the facility's monthly		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573			A. BUILDING <u>01</u> COM			COMPI	TE SURVEY MPLETED 02/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE			
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, T			HE		ETOWN, IN 47356			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APPROPRIATE		ATE	COMPLETION DATE		
					Preventive Maintenance Prog	ıram		
					and document those inspection	on		
					results as appropriate. If any			
					issues are discovered, they w	ill be		
					addressed and resolved			
					immediately. The Maintenanc Supervisor/designee will revie			
					with the Administrator the	. v √		
					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:	/ill		
					a The inspection results we be presented by the Maintena			
					Supervisor/designee to the	11100		
				Administrator monthly and the	9			
				Administrator will present the				
				inspection results at the mont	hly			
					Quality Assurance/Performan	ce		
					Improvement (QA/PI) meeting	-		
					Inspection results and system			
					components will be reviewed	by		
					the QA/PI Committee with	n		
					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 wit	h		
					all regulatory requirements.			
					Our date of compliance is			
					10/25/2023.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155573	B. WING			10/02/2023	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, TI			HE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0914	NFPA 101						
SS=F		s - Maintenance and					
Bldg. 01	Testing						
	I -	s - Maintenance and					
	Testing						
		ceptacles at patient bed					
		re deep sedation or general					
		inistered, are tested after					
		replacement or servicing.					
	_	is performed at intervals					
	I -	ented performance data.					
	1	sted as hospital-grade at					
		e tested at intervals not					
		nths. Line isolation monitors					
	, ,	are tested at intervals of					
		to 1 month by actuating					
		n per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
		utomated self-testing, this					
	I	formed at intervals less					
	than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or						
•		electric distribution system.					
	Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and						
	results.						
	6.3.4 (NFPA 99) Based on record review, observation and			114	VO44 It is the intent of the for	oility	10/25/2023
	interview; the facili		K 09	714	K914 It is the intent of the factor to ensure documentation of	Jilly	10/23/2023
		lectrical outlet receptacle			electrical outlet receptacle tes	tina	
		nt rooms was available for			for all resident rooms is availa	-	
	_	ce with NFPA 99. NFPA 99,			for review in accordance with	DIC	
		es Code, 2012 Edition, Section			NFPA 99 to meet set standard	łe	
	6.3.4.1.3 states rece				1 CORRECTIVE ACTIONS		
		tient bed locations and in			TAKEN:	•	
					a On 10/23/2023 the		
	locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care			ļ	Maintenance Supervisor/designee		
					completed the annual inspecti		
		2 Edition, Section 6.3.4.1.1			of the electrical receptacles	O11	

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/02/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE THE MIDDLETOWN, IN 47356					
(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)	ATE	(X5) COMPLETION DATE	
TAG	states hospital-grade performed after init servicing of the dev Receptacle Testing the physical integrit confirmed by visual the grounding circu shall be verified. Coneutral connections shall be confirmed; grounding blade of (except locking-type than 115 grams (4 of states, at a minimum date, the rooms or a of which items have	e receptacles testing shall be ial installation, replacement or ice. Section 6.3.3.2, in Patient Care Rooms requires y of each receptacle shall be inspection. The continuity of it in each electrical receptacle orrect polarity of the hot and in each electrical receptacle and retention force of the each electrical receptacle erceptacles) shall be not less ounces). Section 6.3.4.2.1.2 in, the record shall contain the reas tested, and an indication ermet, or have failed to meet, quirements of this chapter.		TAG	installed in resident sleeping rooms throughout the building documented the results on the Annual Receptacle Testing Lot the Life Safety Binder to meet standards. The Administrator verified the inspections were complete and plan was documented to replace on 10/16/2023. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTIAL AND AFFECTIAL AND ASSIGNMENT ASSIGNMENT AND ASSIGNMENT ASSIGNMENT ASSIGNMENT AND ASSIGNMENT ASSIGNMENT ASSIGNMENT ASSIGNMENT ASSIGNMENT ASSIGNMENT ASSIGNMEN	e og in : set ED: f	DATE	
	Administrator and I 10/02/23 between 9 itemized listing of it outlet receptacles in recent twelve-month review. The most refor review showed to a three-day period of The Director of Magotten around to do year. The finding was review.	riew and interview with the Director of Maintenance on :50 a.m. and 12:30 p.m., an inspection and testing electrical a resident rooms for the most in period was not available for ecent documentation provided the testing was completed over lated March 7, 8 and 9 of 2022. Intenance stated he had not ing the receptacle testing this riewed with the Director of time of discovery and again ference with the Administrator intenance present.			Administrator in-service the Maintenance Supervisor/design on the requirement that electric receptacles in resident sleeping rooms must be tested annually and documented on the Annu Receptacle Testing Log in the Safety Binder to meet set standards. b Maintenance Supervisor/designee will ensure properly test electrical receptations talled in resident sleeping rooms throughout the building annually as part of the facility' Preventive Maintenance Progrand document those inspection results on the Annual Receptations are discovered, they waddressed and resolved immediately. The Maintenance	ical ing y al e Life re to acles ram on acle If any ill be		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01			COMPLETED			
155573			B. WING			10/02/2023			
				·					
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD						
WAY TED					ECHWOOD AVE				
WATERS	S OF MIDDLETON	/N SKILLED NURSING FACILITY, 1	HE	MIDDLE	ETOWN, IN 47356				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE		
			Supervisor/designee will rev			ew .			
					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 w				
					be presented by the Maintena	ance			
					Supervisor/designee to the				
					Administrator annually and th	е			
					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	Dy			
					subsequent plans of correction	n			
					developed and implemented				
					deemed necessary to ensure				
					compliance is maintained.				
					This plan of correction				
					constitutes our credible				
					allegation of compliance wit	h			
					all regulatory requirements.				
					Our date of compliance is				
					10/25/2023.				

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