Chris Peter

continued program participation.

PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

10/08/2024

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155211	A. BU B. WI	JILDING NG		COMPLETED 09/23/2024	
100211			Б. W				202 1
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WATERS OF LEBANON, THE				1585 PERRY WORTH RD LEBANON, IN 46052			
(X4) ID	SUMMARY S	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 E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
2.03.		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000			
	Survey Date: 09/23	/24					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 1002	290470					
		Preparedness survey, The					
	Waters of Lebanon was found in compliance with						
	Emergency Preparedness Requirements for						
	Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73						
	und Suppliers, 12 C.	1103.73					
	The facility has 64 certified beds. At the time of the survey, the census was 44.						
	Quality Review completed on 09/25/24						
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 483.90(a). Survey Date: 09/23/24		K 0	000	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	n	
	P 42. 37 1 2	00110			facility of the facts alleged or	r	
	Facility Number: 000118 Provider Number: 155211				conclusions set forth in this	20	
	AIM Number: 1002				statement of deficiencies. The plan of correction and specific		
		· · ·			corrective actions are prepar		
		Code survey, The Waters of			and/or executed in compliand		
	Lebanon was found	not in compliance with			with state and federal laws.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN.				3	TITLE		(X6) DATE

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

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Administrator

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155211		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2024	
	PROVIDER OR SUPPLIER		1585 F	ADDRESS, CITY, STATE, ZIP COD PERRY WORTH RD NON, IN 46052	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	Life Safety from Fir National Fire Protec Life Safety Code, (I Health Care Occupa	articipation in , 42 CFR Subpart 483.90(a), re, and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of		This plan of correction constitutes a written allegati of substantial compliance w Federal Medicare and Medicaid requirements.	
	Type V (111) const sprinklered. The fac with smoke detection open to the corridor smoke detectors in a The facility has not is separated by a contherefore used priming has also leased space company that has a some of the space of	ruction and was fully bility has a fire alarm system on in the corridors, spaces and has battery powered all resident sleeping rooms. The sident sleeping rooms are sidents on the 300 hall, and it de access door and is arily for storage. The facility are to Renpro, a dialysis training facility located within the 300 hall. The facility has I had a census of 44 at the time			
	were sprinklered. A services are sprinkle building housing the not sprinklered.	idents have customary access Il areas providing facility ered except for one detached e facility fire pump which is inpleted on 09/25/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors				
	failed to ensure the 7 exits were readily without a clinical di security measures. I of egress shall not b	on and interview, the facility means of egress through 1 of accessible for residents agnosis requiring specialized Doors within a required means be equipped with a latch or the use of a tool or key from the	K 0222	K222 – It is the intent of the factor to ensure the means of egress through exit doors are readily accessible for residents withor clinical diagnosis requiring specialized security measures meet set standards.	s ut a

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155211			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/23/2024		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 1585 PERRY WORTH RD				
WATERS OF LEBANON, THE				LEBAN	ION, IN 46052			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	_	otherwise permitted by LSC			1 CORRECTIVE ACTIONS	3		
		cking arrangements shall be			TAKEN:			
	*	lance with 19.2.2.2.5.2. This			a On 10/4/24 the Maintena	ance		
	_	ould affect as many as 12			Supervisor/designee posted			
		nd 2 visitors if needing to exit			instructions on how to obtain t			
	the facility.				code at the main entrance / ex			
	Fig. 41				doors to the facility to meet se standards. The Administrator			
	Findings include:				verified the work on 10/4/24.			
	Based on observati	one made with the						
		tor during a tour of the facility			2 ALL OTHERS WITH POTENTIAL TO BE AFFECTI	=D:		
		1/23/24, the main entrance / exit			a All residents and all staf			
					and visitors have the potential			
	doors to the facility were marked as a facility exit, were magnetically locked, and could be opened by				be affected but none were. O			
	entering a four-digit code but the code was not				10/3/24 the Maintenance	11		
	posted at the exit. Based on interview at the time				Supervisor/designee inspecte	lle h		
	of the observation, the Maintenance Director				doors and found no other neg			
	stated the aforementioned door was indeed				findings.	ativo		
	marked as an exit, could be opened by entering a				3 MEASURES TO PREVE	NT		
		t the code was not posted at			REOCCURRENCE:			
	_	ore, the Maintenance Director			a On 10/3/24 the			
		ust changed the door codes			Administrator inserviced the			
		on the first day of the month, so			Maintenance Supervisor/desig	nee		
		le was posted guessing that a			and all staff to ensure means	-		
		nad peeled the sticker			egress through exit doors are			
	containing the door	code off the keypad where it			readily accessible for resident	s		
	was usually attache	ed to.			without a clinical diagnosis			
					requiring specialized security			
	This item was discu	ussed with the facility			measures including information	n		
	Administrator at th	e exit conference.			posted on how to obtain the c	odes		
					to meet set standards.			
	3.1-19(b)				b Maintenance			
					Supervisor/designee will ensu	re		
					means of egress through exit			
					doors are readily accessible for	or		
					residents without a clinical			
					diagnosis requiring specialize	d		
					security measures including			
					information posted on how to			
			1		Abtain the codes as a part of t	ho	ı	

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY	
155211		B. WING	<u>U I </u>	COMPLETED 09/23/2024	
		100211	D. WING		0312312024
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
				ERRY WORTH RD	
WATERS	OF LEBANON, TH	1 E	LEBAN	ION, IN 46052	
(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 APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				facility's monthly Preventive	
				Maintenance Program and	
				document those inspection re	
				as appropriate. If any issues	
				discovered, they will be addre	
				and resolved immediately. The Maintenance Supervisor/desi	
				Maintenance Supervisor/desi will review with the Administra	-
				the inspection results.	alui
				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 v	vill
				be presented by the Maintena	ance
				Supervisor/designee to the	
				Administrator monthly and the	
				Administrator will present the	
				inspection results at the mont	•
				Quality Assurance/Performar	
				Improvement (QA/PI) meeting Inspection results and system	-
				components will be reviewed	
				the QA/PI Committee with	Sy
				subsequent plans of correction	on
				developed and implemented	
				deemed necessary to ensure	
				compliance is maintained.	
				This plan of correction	
				constitutes our credible	
				allegation of compliance wit	th
				all regulatory requirements.	
				Our date of compliance is	
				10/8/24.	
				1	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/23/2024 155211 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1585 PERRY WORTH RD WATERS OF LEBANON, THE LEBANON, IN 46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0761 **NFPA 101** SS=E Maintenance, Inspection & Testing - Doors Bldg. 01 Based on observation and interview, the facility K 0761 10/29/2024 failed to ensure the proper operation was K761 - It is the intent of the maintained for 1 of 1 rolling steel fire door was in facility to ensure proper operation accordance with NFPA 80. LSC 4.5.8 requires any is maintained for rolling steel fire device, equipment, system, condition, doors and is in accordance with arrangement, level of protection, or any other NFPA 80 to meet set standards. **CORRECTIVE ACTIONS** feature is required for compliance with the 1 provision of this Code, such device, equipment, TAKEN: system, condition, arrangement, level of On 10/8/24 the Maintenance protection, or other feature shall thereafter be Supervisor/overhead door maintained unless the Code exempts such contractor/designee removed the maintenance. NFPA 80, 2010 Edition, the Standard two by four from the metal rolling for Fire Doors and Other Opening Protectives, fire door between the kitchen and Section 11.4.1.1 requires an automatic-closing main dining room to meet set device shall be installed on every rolling steel standards. The Administrator door. Section 11.4.1.2 states rolling steel doors verified the work on 10/8/24. shall close automatically upon activation or By 10/29/24 the release of a fusible link or detector. Section Maintenance Supervisor/overhead 11.4.2.2.1 states after the automatic closing is door contractor/designee will activated, the door shall remain in the closed make repairs to the door to meet position until the automatic-closing device has set standards. The Administrator been reset. This deficient practice could affect as will verify the work upon many as 35 residents, 10 staff and 4 visitors in the completion. main dining room and kitchen areas. **ALL OTHERS WITH** POTENTIAL TO BE AFFECTED: Findings include: All residents and all staff and visitors have the potential to Based on observations made with the be affected but none were. Maintenance Director during a tour of the facility **MEASURES TO PREVENT** at 1:12 p.m. on 09/23/24, the metal rolling fire door REOCCURRENCE: between the kitchen and main dining room, which On 10/3/24 the was open to the corridor, was held open with a Administrator inserviced the wooden two by four. Based on interview at the Maintenance Supervisor/designee time of observation, the Maintenance Director and all dietary staff on the stated that he was aware of the two by four being requirement to ensure proper used as the door had malfunctioned and that his operation is maintained for rolling vendor was scheduled to be at the facility this steel fire doors including no

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155211	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2024				
NAME OF PROVIDER OR SUPPLIER WATERS OF LEBANON, THE			1585 F	STREET ADDRESS, CITY, STATE, ZIP COD 1585 PERRY WORTH RD LEBANON, IN 46052					
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	TION (X5) JLD BE COMPLETION ROPRIATE DATE				
	week to make the n fire door.	ecessary repairs on the rolling		obstructions to closing to set standards. b Maintenance	meet				
	This item was discu Administrator at the	assed with the facility e exit conference.		Supervisor/designee will proper operation is maint rolling steel fire doors inc	tained for				
	3.1-19(b)			obstructions to closing as the facility's monthly Prev Maintenance Program ar	s a part of ventive nd				
				document those inspection as appropriate. If any is discovered, they will be a and resolved immediately	sues are addressed				
				Maintenance Supervisor/ will review with the Admitthe inspection results.	/designee				
				c The Administrator v monitor adherence to the Preventative Maintenance					
				schedule and validate the Preventative Maintenanc documentation is in place	e ee				
				4 MONITORING CORRECTIVE ACTION: a The inspection resu					
				be presented by the Mair Supervisor/designee to the Administrator monthly an	ntenance he				
				Administrator will presentinspection results at the Quality Assurance/Performa	monthly				
				Improvement (QA/PI) me Inspection results and sy components will be revie	rstem				
				the QA/PI Committee wit subsequent plans of corr developed and implemen	ection nted as				
				deemed necessary to en compliance is maintained This plan of correction					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155211		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/23/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF LEBANON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1585 PERRY WORTH RD LEBANON, IN 46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
					constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/29/24.	1	

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