STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155211	A. BUILDING -- B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF LEBANON, THE	1585 PERRY WORTH RD LEBANON, IN 46052

(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: 09/23/24 Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470 At this Emergency 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 The facility has 64 certified beds. At the time of the survey, the census was 44. Quality Review completed on 09/25/24	E 0000		
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 Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470 At this Life Safety Code survey, The Waters of Lebanon was found not in compliance with	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, 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
Chris Peter	Administrator	10/08/2024

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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	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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has no residents on the 300 hall, and it is separated by a code access door and is therefore used primarily for storage. The facility has also leased space to Renpro, a dialysis company that has a training facility located within some of the space on the 300 hall. The facility has a capacity of 64 and had a census of 44 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services are sprinklered except for one detached building housing the facility fire pump which is not sprinklered. Quality Review completed on 09/25/24		**This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the	K 0222	**K222**– It is the intent of the facility to ensure the means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures meet set standards.	10/08/2024

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	egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors if needing to exit the facility. Findings include: Based on observations made with the Maintenance Director during a tour of the facility at 11:38 a.m. on 09/23/24, the main entrance / exit doors to the facility were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code but the code was not posted at the exit. Based on interview at the time of the observation, the Maintenance Director stated the aforementioned door was indeed marked as an exit, could be opened by entering a four-digit code, but the code was not posted at the door. Furthermore, the Maintenance Director added that he had just changed the door codes within the facility on the first day of the month, so he was sure the code was posted guessing that a resident or visitor had peeled the sticker containing the door code off the keypad where it was usually attached to. This item was discussed with the facility Administrator at the exit conference. 3.1-19(b)		1 **CORRECTIVE ACTIONS TAKEN**: a On 10/4/24 the Maintenance Supervisor/designee posted instructions on how to obtain the code at the main entrance / exit doors to the facility to meet set standards. The Administrator verified the work on 10/4/24. 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 10/3/24 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/3/24 the Administrator inserviced the Maintenance Supervisor/designee and all staff to ensure means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures including information posted on how to obtain the codes to meet set standards. b Maintenance Supervisor/designee will ensure means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures including information posted on how to obtain the codes as a part of the	

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			facility's monthly 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 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 10/8/24.**	

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K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation and interview, the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel fire door was in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect as many as 35 residents, 10 staff and 4 visitors in the main dining room and kitchen areas. Findings include: Based on observations made with the Maintenance Director during a tour of the facility at 1:12 p.m. on 09/23/24, the metal rolling fire door between the kitchen and main dining room, which was open to the corridor, was held open with a wooden two by four. Based on interview at the time of observation, the Maintenance Director stated that he was aware of the two by four being used as the door had malfunctioned and that his vendor was scheduled to be at the facility this	K 0761	**K761** – It is the intent of the facility to ensure proper operation is maintained for rolling steel fire doors and is in accordance with NFPA 80 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10/8/24 the Maintenance Supervisor/overhead door contractor/designee removed the two by four from the metal rolling fire door between the kitchen and main dining room to meet set standards. The Administrator verified the work on 10/8/24. b By 10/29/24 the Maintenance Supervisor/overhead door contractor/designee will make repairs to the door to meet set standards. The Administrator will verify the work upon completion. 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 10/3/24 the Administrator inserviced the Maintenance Supervisor/designee and all dietary staff on the requirement to ensure proper operation is maintained for rolling steel fire doors including no	10/29/2024

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	week to make the necessary repairs on the rolling fire door. This item was discussed with the facility Administrator at the exit conference. 3.1-19(b)		obstructions to closing to meet set standards. b Maintenance Supervisor/designee will ensure proper operation is maintained for rolling steel fire doors including no obstructions to closing as a part of the facility's monthly 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 deemed necessary to ensure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/29/24.	