PRINTED: 07/08/2025 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07/	01/2025	
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
	An Emergency Prepa conducted by the Indi accordance with 42 C	ana Department of Health in						
	Survey Dates: 06/30/ Facility Number: 011/ Provider Number: 15 AIM Number: 200909	509 5770						
	Waters of Georgetow with Emergency Prep	eparedness survey, The n was found in compliance aredness Requirements for id Participating Providers R 483.73						
	The facility has 68 cecensus of 67.	rtified beds, with a current						
K 000	Quality Review compl INITIAL COMMENTS		K	000				
	Licensure Survey was	ecertification and State s conducted by the Indiana in accordance with 42 CFR						
	Survey Dates: 06/30/	/25 and 07/01/25						
	Facility Number: 011a Provider Number: 15 AIM Number: 200909	5770						
	Georgetown, was fou Requirements for Par	de survey, The Waters of nd not in compliance with ticipation in 2 CFR Subpart 483.90(a),						

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03 , 04 , 05 , 06 , 07 , 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07/01/2025	
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY EORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	National Fire Protectic Life Safety Code (LSG 1002 was surveyed with Health Care Occupant) This one story facility Type V (111) construct facility has a fire alarm detection in the corridorridors, and all residuality has a capacity 10 at the time of this with All areas where residual were sprinkled and all services were sprinkled Quality Review comp	and the 2012 edition of the on Association (NFPA) 101, C), and 410 IAC 16.2. Villa with Chapter 19, Existing acies. was determined to be of ction and fully sprinkled. The maystem with smoke lors, spaces open to the dent sleeping rooms. The of 10 and had a census of visit. ents have customary access I areas providing facility ed.		0000			
K 000	Licensure Survey was Department of Health 483.90(a). Survey Dates: 06/30/2 Facility Number: 011 Provider Number: 15 AIM Number: 200909 At this Life Safety Code Georgetown, was four Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a	ecertification and State s conducted by the Indiana in accordance with 42 CFR //25 and 07/01/25 509 5770 9280 de survey, The Waters of nd not in compliance with		000			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03 , 04 , 05 , 06 , 07 , 08		' '	(X3) DATE SURVEY COMPLETED	
		155770	B. WING _		0	7/01/2025	
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
K 000	1004 was surveyed we Health Care Occupant. This one story facility Type V (111) construct facility has a fire alarm detection in the corrid corridors, and all residuality has a capacity at the time of this visit. All areas where reside	C), and 410 IAC 16.2. Villa vith Chapter 19, Existing noies. was determined to be of ction and fully sprinkled. The m system with smoke dors, spaces open to the dent sleeping rooms. The rof 10 and had a census of 9 t. ents have customary access il areas providing facility ed.	K	000			
K 000	Licensure Survey was Department of Health 483.90(a). Survey Dates: 06/30/ Facility Number: 011: Provider Number: 15 AIM Number: 200909 At this Life Safety Cod Georgetown, was fou Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSC)	decertification and State s conducted by the Indiana in accordance with 42 CFR /25 and 07/01/25 509 55770 9280 de survey, The Waters of and not in compliance with	K	000			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07/01/2025	
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY SEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	Type V (111) construct facility has a fire alarm detection in the corridors, and all residuality has a capacity 10 at the time of this value areas where residually were sprinkled and all services were sprinkled Quality Review comp	was determined to be of ction and fully sprinkled. The m system with smoke lors, spaces open to the dent sleeping rooms. The of 10 and had a census of visit. ents have customary access I areas providing facility ed.		0000			
K 000	Licensure Survey was Department of Health 483.90(a). Survey Dates: 06/30/ Facility Number: 011 Provider Number: 15 AIM Number: 200909 At this Life Safety Codeorgetown, was fou Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protection Life Safety Code (LSG)	ecertification and State s conducted by the Indiana in accordance with 42 CFR /25 and 07/01/25 509 5770 9280 de survey, The Waters of and not in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), and 410 IAC 16.2. Villa with Chapter 19, Existing	K	000			

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 07/08/2025 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING _		07	//01/2025	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WATERS (OF GEORGETOWN, THE			1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 000	Type V (111) construct facility has a fire alarm detection in the corridors, and all residuality has a capacity 10 at the time of this value and all services were sprinkled and all services	was determined to be of ction and fully sprinkled. The in system with smoke lors, spaces open to the dent sleeping rooms. The of 10 and had a census of visit. ents have customary access I areas providing facility ed. leted on 07/02/25 eccertification and State is conducted by the Indiana in accordance with 42 CFR //25 and 07/01/25 509 5770 9280 de survey, The Waters of ind not in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), and 410 IAC 16.2. Villa vith Chapter 19, Existing	К0				
		ction and fully sprinkled. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03 , 04 , 05 , 06 , 07 , 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING _			07/01/2025
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
K 000	corridors, and all residence facility has a capacity 10 at the time of this was All areas where residence were sprinkled and all services were sprinkled	n system with smoke ors, spaces open to the dent sleeping rooms. The of 10 and had a census of visit. ents have customary access I areas providing facility ed.	К 0	00		
K 000	Licensure Survey was Department of Health 483.90(a). Survey Date: 06/30/2 Facility Number: 011. Provider Number: 15 AIM Number: 200908 At this Life Safety Cod Georgetown, was fou Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSC 1007 was surveyed whealth Care Occupant This one story facility Type V (111) construct facility has a fire alarm	ecertification and State s conducted by the Indiana in accordance with 42 CFR 25 and 07/01/25 509 5770 50280 500 500 500 500 500 500 500 500 500 5	К 0	00		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING _			07/	01/2025
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			10	REET ADDRESS, CITY, STATE, ZIP CODE 02 SISTER BARBARA WAY EORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	facility has a capacity 10 at the time of this value All areas where reside	dent sleeping rooms. The of 10 and had a census of	КО	000			
K 000	Quality Review compi INITIAL COMMENTS A Life Safety Code R Licensure Survey was	ed.	КС	000			
	483.90(a). Survey Dates: 06/30/ Facility Number: 011: Provider Number: 15 AIM Number: 200909 At this Life Safety Cod Georgetown, was fou Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSC 1008 was surveyed w Health Care Occupan This one story facility Type V (111) construct facility has a fire alarm detection in the corrid corridors, and all resid	25 and 07/01/25 509 5770 9280 de survey, The Waters of and not in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), and 410 IAC 16.2. Villa ith Chapter 19, Existing cies. was determined to be of tion and fully sprinkled. The					

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG 01, 03, 04, 05, 06, 07, 08		(X3) DATE SURVEY COMPLETED	
		155770	B. WING _		-	07/01/2025	
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE			STREET ADDRESS, CITY, STA 1002 SISTER BARBARA WA GEORGETOWN, IN 4712	AY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)	DATE	
K 000			K	00			
K 921 SS=F	services were sprinkle Quality Review comp	ed.	K	21			
	Requirements The physical integrity current, and touch cur portable patient-care (PCREE) is performer Testing intervals are exprotocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances of with NFPA 99 as a comanuals, instructions by the manufacturer in required by 10.5.3.1.1 development of a pro- equipment maintenant instructions and main available, and safety operating instructions legible. A record of elerepairs, and modificat period of time to demi- accordance with the f	rrent tests for fixed and related electrical equipment d as required in 10.3. established with policies and used in patient care rooms are with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance in mplete system. Service and procedures provided include information as and are considered in the gram for electrical equipment in tenance manuals are readily labels and condensed on the appliance are estrical equipment tests, ions is maintained for a constrate compliance in acility's policy. Personnel esting, maintenance and use					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION 1, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07/	01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, TH	IE .	1	10	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY BEORGETOWN, IN 47122	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 921	10.5.6, 10.5.8 This REQUIREMEN by: Based on record re interview, the facility maintenance and m documentation of in Related Electrical E 2012 edition, sectio physical integrity, re and touch current te PCREE is performe intervals are establi protocols. All PCRE is tested in accorda before being put into or modification. An electrical appliances with NFPA 99 as a c manuals, instruction by the manufacture required by 10.5.3.1 development of a pre equipment maintens instructions and ma available, and safet operating instruction legible. A record of repairs, and modific period of time to de accordance with the responsible for the of of electrical appliance	IT is not met as evidenced eview, observation, and a failed to conduct the required elinitain complete espections for Patient Care equipment (PCREE). NFPA 99 ens 10.3 and 10.5 states the esistance, leakage current, ests for fixed and portable d as required in 10.3. Testing eshed with policies and est used in patient care rooms ence with 10.3.5.4 or 10.3.6 to service and after any repair ey system consisting of several est demonstrates compliance complete system. Service ens, and procedures provided in include information as 1.1 and are considered in the	K	921			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04, 05, 06, 07, 08			(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07/01/2025	
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY EORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 921	a.m. with the Administ Assistant, and Mainter facility present, there the testing of PCREE nebulizers, oxygen or air mattresses, and of equipment. Based or during record review, and Maintenance Assout about the requirer facility has not tested PCREE items yet. Brown of all se Regional Property Mafacility provided PCR oxygen concentrators mattresses, and othe equipment was present.	ew on 06/30/25 at 10:15 strator, Maintenance enance Director from a sister was no documentation for for the second	К	921			
K 921 SS=F	Regional Property Ma Director of Operations on 07/01/25. 3.1-19(b) Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Requirements The physical integrity current, and touch cu portable patient-care (PCREE) is performe Testing intervals are e	- Testing and Maintenanc - Testing and Maintenanc - Testing and Maintenance , resistance, leakage rrent tests for fixed and related electrical equipment	К	921			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING _		07/01/2025
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	1 0110112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
K 921	before being put into or modification. Any electrical appliances with NFPA 99 as a comanuals, instruction by the manufacturer required by 10.5.3.1 development of a prequipment maintenainstructions and mainstructions and modific period of time to deraccordance with the responsible for the tof electrical appliance training. 10.3, 10.5.2.1, 10.5.10.5.8 This REQUIREMENTAL Based on record responsible for the tof electrical appliance training. 10.3, 10.5.2.1, 10.5.10.5.8 This REQUIREMENTAL Based on record responsible for the tof electrical appliance training. 10.5.6, 10.5.8 This REQUIREMENTAL Based on record responsible for the facility maintenance and mainten	nce with 10.3.5.4 or 10.3.6 o service and after any repair system consisting of several demonstrates compliance complete system. Service s, and procedures provided include information as .1 and are considered in the ogram for electrical ance. Electrical equipment intenance manuals are readily y labels and condensed as on the appliance are electrical equipment tests, ations is maintained for a monstrate compliance in facility's policy. Personnel esting, maintenance and use ces receive continuous 2.1.2, 10.5.2.5, 10.5.3, IT is not met as evidenced view, observation, and y failed to conduct the required	K 9	21	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING _		07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	1 01/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
K 921	manuals, instructions by the manufacturer required by 10.5.3.1. development of a proequipment maintenarinstructions and mair available, and safety operating instructions legible. A record of repairs, and modifica period of time to demaccordance with the responsible for the te of electrical appliance training. This deficie residents. Findings include: Based on record revial. Maintefacility present, there the testing of PCREE nebulizers, oxygen cair mattresses, and dequipment. Based of during record review, and Maintenance Assout about the requirefacility has not tested PCREE items yet. B 07/01/25 between 9: during a tour of all se Regional Property Maintenance Property Maintenance Regional Property Maintenance Regio	emplete system. Service include information as and are considered in the orgam for electrical equipment intenance manuals are readily labels and condensed in the appliance are electrical equipment tests, and the appliance in facility's policy. Personnel esting, maintenance and use in facility's policy. Personnel esting, maintenance and use in the practice could affect all in the practice could affect all in the practice in facility is policy. Personnel esting, maintenance and use in the practice could affect all in the practice could affect all in the practice in the maintenance in the maintenance in the maintenance in interview at 10:15 a.m. In the Maintenance Director in the Maintenance Director in the Maintenance in the ma	KS	021	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG 01 , 03 , 04 , 05 , 06 , 07 , 08		(X3) DATE SURVEY COMPLETED
		155770	B. WING			07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE		•	STREET ADDRESS, CITY, STATE, Z 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
K 921	Regional Property Ma	nt in the facility.	K	921		
K 921 SS=F	CFR(s): NFPA 101	- Testing and Maintenanc - Testing and Maintenance	K s	921		
	The physical integrity current, and touch cuportable patient-care (PCREE) is performed Testing intervals are exprotocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances with NFPA 99 as a commanuals, instructions by the manufacturer in required by 10.5.3.1. development of a proequipment maintenar instructions and main available, and safety operating instructions legible. A record of el repairs, and modificat period of time to demaccordance with the formatical process.	rrent tests for fixed and related electrical equipment d as required in 10.3. established with policies and used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance in mplete system. Service and procedures provided include information as and are considered in the gram for electrical equipment intenance manuals are readily labels and condensed in the appliance are ectrical equipment tests, tions is maintained for a constrate compliance in facility's policy. Personnel esting, maintenance and use				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 1, 03, 04, 05, 06, 07, 08	(X3) DATE COMP	SURVEY
		155770	B. WING			07/	01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY SEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 921	10.5.6, 10.5.8 This REQUIREMENT by: Based on record revi interview, the facility f maintenance and maidocumentation of instructions physical integrity, resi and touch current tes PCREE is performed intervals are establish protocols. All PCREE is tested in accordance before being put into or modification. Any electrical appliances with NFPA 99 as a comanuals, instructions by the manufacturer i required by 10.5.3.1.1 development of a proequipment maintenarinstructions and main available, and safety operating instructions legible. A record of erepairs, and modificate period of time to demaccordance with the fresponsible for the terof electrical appliance.	ew, observation, and failed to conduct the required intain complete opections for Patient Care Lipment (PCREE). NFPA 99 is 10.3 and 10.5 states the distance, leakage current, its for fixed and portable as required in 10.3. Testing and with policies and E used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance in and procedures provided include information as and are considered in the gram for electrical equipment tenance manuals are readily labels and condensed on the appliance are lectrical equipment tests, tions is maintained for a constrate compliance in facility's policy. Personnel sting, maintenance and use	K	921			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION 1, 03, 04, 05, 06, 07, 08	(X3) DATE COMP	SURVEY PLETED
		155770	B. WING			07/	01/2025
	ROVIDER OR SUPPLIER DF GEORGETOWN, TH	IE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY BEORGETOWN, IN 47122	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 921		view on 06/30/25 at 10:15	K	921			
	Assistant, and Mair facility present, ther the testing of PCRE nebulizers, oxygen air mattresses, and equipment. Based during record review and Maintenance A out about the requir facility has not teste PCREE items yet. 07/01/25 between 9 during a tour of all s Regional Property Macility provided PC oxygen concentrate	distrator, Maintenance of tenance Director from a sister of was no documentation for the second as electric beds, concentrators, air pumps for other electrical medical on interview at 10:15 a.m. of the Maintenance Director of the sistant said they just found the second and documented the second and documented the second of					
	This finding was rev	viewed with the Administrator, Manager, and Regional ons during the exit conference					
K 921 SS=F	3.1-19(b) Electrical Equipmer CFR(s): NFPA 101	nt - Testing and Maintenanc	K	921			
	Requirements The physical integri current, and touch of portable patient-car (PCREE) is perform	ty, resistance, leakage current tests for fixed and e related electrical equipment ned as required in 10.3.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01, 03, 04, 05, 06, 07, 08		TE SURVEY MPLETED
		155770	B. WING _			07/01/2025
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1002 SISTER BARBARA WAY		
WATERS	OF GEORGETOWN, THE			GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 921	is tested in accordance before being put into or modification. Any selectrical appliances with NFPA 99 as a comanuals, instructions by the manufacturer in required by 10.5.3.1.1 development of a proequipment maintenar instructions and main available, and safety operating instructions legible. A record of el repairs, and modificate period of time to demaccordance with the foresponsible for the teof electrical appliance training. 10.3, 10.5.2.1, 10.5.2.1, 10.5.8. This REQUIREMENT by:	is used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance omplete system. Service of and procedures provided include information as 1 and are considered in the gram for electrical nece. Electrical equipment of the appliance are readily labels and condensed on the appliance are rectrical equipment tests, tions is maintained for a constrate compliance in facility's policy. Personnel sting, maintenance and use	К9	,		
	interview, the facility in maintenance and madocumentation of inspace Related Electrical Equipment 2012 edition, sections physical integrity, resumed touch current tespected intervals are establish protocols. All PCREE is tested in accordance before being put into	failed to conduct the required intain complete pections for Patient Care uipment (PCREE). NFPA 99 is 10.3 and 10.5 states the istance, leakage current, its for fixed and portable as required in 10.3. Testing				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING _		_	07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE	<u> </u>	1	STREET ADDRESS, CITY, S' 1002 SISTER BARBARA W GEORGETOWN, IN 471	WAY	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 921	with NFPA 99 as a comanuals, instructions by the manufacturer required by 10.5.3.1. development of a proequipment maintenainstructions and mair available, and safety operating instructions legible. A record of erepairs, and modificate period of time to demaccordance with the responsible for the test of electrical appliance training. This deficience in the end of the electrical appliance training. This deficience in the electrical appliance training. This deficience in the electrical appliance training. This deficience in the electrical appliance training. This deficience is a multiple in the electrical appliance training. This deficience is a multiple in the electrical appliance training include: Based on record review a.m. with the Administ Assistant, and Mainte facility present, there the testing of PCREE nebulizers, oxygen cair mattresses, and dequipment. Based of during record review and Maintenance Assout about the require facility has not tested PCREE items yet.	demonstrates compliance omplete system. Service of and procedures provided include information as 1 and are considered in the orgam for electrical equipment intenance manuals are readily labels and condensed of on the appliance are electrical equipment tests, ations is maintained for a monstrate compliance in facility's policy. Personnel esting, maintenance and use es receive continuous int practice could affect all	K	021		
	during a tour of all se Regional Property M	even buildings with the anager it was revealed the EE such as electric beds,				

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG 01, 03, 04, 05, 06, 07	, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING _			07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE		•	STREET ADDRESS, C 1002 SISTER BARBA GEORGETOWN, IN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)	
K 921 K 921 SS=F	Regional Property Ma Director of Operations on 07/01/25.	r electrical medical nt in the facility. ewed with the Administrator,	K s			
	Electrical Equipment Requirements The physical integrity current, and touch cu portable patient-care (PCREE) is performe Testing intervals are of protocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances with NFPA 99 as a co manuals, instructions by the manufacturer if required by 10.5.3.1. development of a pro- equipment maintenar instructions and main available, and safety operating instructions legible. A record of el repairs, and modificar period of time to dem accordance with the fi	rrent tests for fixed and related electrical equipment d as required in 10.3. established with policies and used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance implete system. Service, and procedures provided include information as a land are considered in the gram for electrical equipment tenance manuals are readily labels and condensed				

1 1	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			E CONSTRUCTION 11, 03, 04, 05, 06, 07, 08	(X3) DATE COMP	SURVEY LETED
	155770	B. WING _			07/	01/2025
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY GEORGETOWN, IN 47122		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 921 Continued From page 18 of electrical appliances rectraining. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.6, 10.5.8 This REQUIREMENT is responsible for the testing of electrical appliances rectraining. Based on record review, or interview, the facility failed maintenance and maintain documentation of inspectic Related Electrical Equipm 2012 edition, sections 10.3 physical integrity, resistant and touch current tests for PCREE is performed as resintervals are established where the protocols. All PCREE used is tested in accordance with before being put into servitor modification. Any system electrical appliances demonstrated by 10.5.3.1.1 and development of a programe equipment maintenance. Instructions and maintenance available, and safety label operating instructions on the legible. A record of electrical appliances rectaining in the total demonstrate accordance with the facility responsible for the testing of electrical appliances rectaining. This deficient pragressidents.	ot met as evidenced observation, and to conduct the required complete ons for Patient Care ent (PCREE). NFPA 99 and 10.5 states the ce, leakage current, fixed and portable equired in 10.3. Testing with policies and d in patient care rooms th 10.3.5.4 or 10.3.6 ce and after any repair m consisting of several onstrates compliance te system. Service procedures provided le information as lare considered in the of or electrical Electrical equipment nee manuals are readily and condensed the appliance are cal equipment tests, is maintained for a cate compliance in y's policy. Personnel maintenance and use delivered in the control of th	K	921			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01, 03, 04, 05, 06, 07, 08		(X3) DATE SURVEY COMPLETED
		155770	B. WING _			07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE			STREET ADDRESS, CITY, STAT 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE SED TO THE APPROPRIA SFICIENCY)	
K 921	a.m. with the Administ Assistant, and Mainter facility present, there the testing of PCREE nebulizers, oxygen coair mattresses, and or equipment. Based or during record review, and Maintenance Assout about the requirer facility has not tested PCREE items yet. Ba 07/01/25 between 9:1 during a tour of all se Regional Property Market Regional Prop	ew on 06/30/25 at 10:15 trator, Maintenance nance Director from a sister was no documentation for such as electric beds, oncentrators, air pumps for ther electrical medical interview at 10:15 a.m. the Maintenance Director istant said they just found ment not long ago and the and documented the ased on observations on 5 a.m. and 12:00 p.m. wen buildings with the anager it was revealed the EE such as electric beds, , air pumps for air relectrical medical	KS	021		
K 921 SS=F	Regional Property Ma Director of Operations on 07/01/25. 3.1-19(b) Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Requirements The physical integrity current, and touch cu	- Testing and Maintenanc - Testing and Maintenanc - Testing and Maintenance , resistance, leakage rrent tests for fixed and related electrical equipment	KS	021		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01, 03, 04, 05, 06, 07, 08	' '	TE SURVEY MPLETED
		155770	B. WING			7/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE	:	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 921	protocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances with NFPA 99 as a comanuals, instructions by the manufacturer is required by 10.5.3.1. development of a proequipment maintenar instructions and main available, and safety operating instructions legible. A record of el repairs, and modifica period of time to dem accordance with the responsible for the teof electrical appliance training. 10.3, 10.5.2.1, 10.5.2.1, 10.5.2.1, 10.5.6, 10.5.8. This REQUIREMENT by: Based on record revinterview, the facility maintenance and madocumentation of ins Related Electrical Eq. 2012 edition, sections physical integrity, resund touch current tes. PCREE is performed intervals are establish protocols. All PCREE is tested in accordance.	established with policies and a used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance omplete system. Service of and procedures provided include information as an and are considered in the gram for electrical equipment of the appliance are ectrical equipment attenance manuals are readily labels and condensed on the appliance are ectrical equipment tests, ations is maintained for a constrate compliance in facility's policy. Personnel sting, maintenance and use as receive continuous 2.1.2, 10.5.2.5, 10.5.3, This is not met as evidenced in the required intain complete pections for Patient Care uipment (PCREE). NFPA 99 as 10.3 and 10.5 states the istance, leakage current, its for fixed and portable as required in 10.3. Testing	K 92	21		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01, 03, 04, 05, 06, 07, 08		TE SURVEY MPLETED
		155770	B. WING _			7/01/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 4	
				1002 SISTER BARBARA WAY		
WATERS	OF GEORGETOWN, THE			GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 921	Continued From page or modification. Any	e 21 system consisting of several	K 9	21		
	electrical appliances	demonstrates compliance omplete system. Service				
	manuals, instructions	, and procedures provided include information as				
	required by 10.5.3.1.1	1 and are considered in the				
	development of a pro	gram for electrical nce. Electrical equipment				
	instructions and main	tenance manuals are readily labels and condensed				
	operating instructions	on the appliance are				
		lectrical equipment tests, tions is maintained for a				
	period of time to dem	onstrate compliance in facility's policy. Personnel				
		sting, maintenance and use				
	of electrical appliance					
	training. This deficier residents.	nt practice could affect all				
	Findings include:					
		ew on 06/30/25 at 10:15				
	a.m. with the Adminis	errator, Maintenance				
	· ·	was no documentation for				
		, such as electric beds,				
		oncentrators, air pumps for				
		ther electrical medical				
		n interview at 10:15 a.m.				
		the Maintenance Director				
		sistant said they just found				
		ment not long ago and the				
	facility has not tested					
	_	ased on observations on				
		15 a.m. and 12:00 p.m. ven buildings with the				
	_	anager it was revealed the				
		EE such as electric beds,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION 01, 03, 04, 05, 06, 07, 08	(X3) DATE SURVEY COMPLETED
		155770	B. WING		07/01/2025
	ROVIDER OR SUPPLIER OF GEORGETOWN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
K 921	Regional Property Ma Director of Operations on 07/01/25.	e, air pumps for air r electrical medical nt in the facility. wed with the Administrator,	K 92	1	
K 921 SS=F	CFR(s): NFPA 101 Electrical Equipment Requirements The physical integrity current, and touch curportable patient-care (PCREE) is performed Testing intervals are exprotocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances of with NFPA 99 as a comanuals, instructions by the manufacturer is required by 10.5.3.1.1 development of a proequipment maintenant instructions and main available, and safety operating instructions legible. A record of elements, and modificat period of time to demonstructions of the property of the period of time to demonstructions of the period of time to demonstructions.	rrent tests for fixed and related electrical equipment d as required in 10.3. established with policies and used in patient care rooms to with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance mplete system. Service, and procedures provided include information as I and are considered in the gram for electrical equipment tenance manuals are readily labels and condensed	K 92		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION 11, 03, 04, 05, 06, 07, 08	(X3) DATE COMP	SURVEY LETED
		155770	B. WING			07/	01/2025
	ROVIDER OR SUPPLIER DF GEORGETOWN, THE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 002 SISTER BARBARA WAY BEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 921	of electrical appliance training. 10.3, 10.5.2.1, 10.5.2 10.5.6, 10.5.8 This REQUIREMENT by: Based on record revinterview, the facility maintenance and madocumentation of inspectations physical integrity, result and touch current tespectations. All PCREE is performed intervals are establish protocols. All PCREE is tested in accordance before being put into or modification. Any electrical appliances with NFPA 99 as a communals, instructions by the manufacturer in required by 10.5.3.1.1 development of a proequipment maintenarinstructions and main available, and safety operating instructions legible. A record of erepairs, and modification period of time to dem accordance with the foresponsible for the teof electrical appliance.	sting, maintenance and use as receive continuous 1.2, 10.5.2.5, 10.5.3, is not met as evidenced iew, observation, and failed to conduct the required intain complete pections for Patient Care uipment (PCREE). NFPA 99 s 10.3 and 10.5 states the istance, leakage current, ts for fixed and portable as required in 10.3. Testing ned with policies and E used in patient care rooms be with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance implete system. Service , and procedures provided include information as 1 and are considered in the gram for electrical ince. Electrical equipment tenance manuals are readily labels and condensed on the appliance are lectrical equipment tests, tions is maintained for a constrate compliance in facility's policy. Personnel sting, maintenance and use	K	921			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03 , 04 , 05 , 06 , 07 , 08		(X3) DATE SURVEY COMPLETED	
		155770	B. WING			07	/01/2025
NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE		COMPLETION
K 921	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		K	921			