STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING -- B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITEWATER COMMONS SENIOR LIVING	215 W HIGH ST LIBERTY, IN 47353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/06/24 Facility Number: 000510 Provider Number: 155507 AIM Number: 100285440 At this Emergency Preparedness survey, Whitewater Commons Senior Living 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 22. Quality Review completed on 08/08/24	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). This visit was in conjunction with the Life Safety Code Complaint Investigation PSR that exited on 08/06/24. Survey Date: 08/06/24 Facility Number: 000510	K 0000	Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Blackmon	HFA	08/19/2024

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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	Provider Number: 155507 AIM Number: 100285440 At this Life Safety Code survey, Whitewater Commons Senior Living was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 22 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 08/08/24		Please accept this Plan of Correction as our credible allegation of compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of over 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents. Findings include: Based upon observation and interview with the Maintenance Director (MD) and Administrator during a facility tour on 08/06/24 between 12:40 p.m. and 2:50 p.m., the exit doors located in (1) The Therapy Hall and (2) Dining Hall into the Smoking Area were provided with delayed egress locks but lacked the proper signage. The lettering font size, contrasting background, and location of the provided signage did not meet the requirements. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress but did not	K 0222	1&2. No residents were affected but all residents had the potential to be affected. The Egress door in the therapy hall and the egress door in the dining hall both have added proper signage stating “Push until alarm sounds. Door can be opened in 15 seconds.” 3. The maintenance director was re-educated on Egress Door requirements. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete. Any negative findings will be corrected immediately and reported to the administrator, a visual inspection of the egress doors will be documented on inspection form, any negative findings will be corrected immediately and reported to the administrator.	08/23/2024

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	appear to have the proper signage. This deficient finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Regional Director of Operations, DON and Administrator all present. 3.1-19(b)		Monitoring will be conducted 5 times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or			

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	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: 1. Based upon observation and interview with the Maintenance Director (MD) and Administrator during a facility tour on 08/06/24 between 12:40 p.m. and 2:50 p.m., the corridor door to Resident Room 201 failed to close and latch positively into the door frame. 2. Based upon observation and interview with the Maintenance Director (MD) and Administrator during a facility tour on 08/06/24 between 12:40 p.m. and 2:50 p.m., between the dining room and kitchen 1 of 2 doors, equipped with self-closing devices, failed to self-close and latch into the door frame. This deficient finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Regional Director of Operations, DON	K 0363	1&2. No residents were affected but all residents had the potential to be affected. The Corridor door to room #201 latch was adjusted and door between the kitchen and dining room was repaired with a steel latch to ensured that the doors latched into the door frame. 3. The maintenance director was re-educated on corridor doors. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete Any negative findings will be corrected immediately and reported to the administrator, a visual inspection of the corridor doors will be documented on inspection form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5	08/23/2024

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	and Administrator all present. 3.1-19(b)		times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) exterior of the properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 2 staff. Findings include: Based upon observation and interview with the Maintenance Director (MD) and Administrator during a facility tour on 08/06/24 between 12:40 p.m. and 2:50 p.m., when the GFCI electric receptacle outside the exit door near Therapy was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work	K 0511	1&2. No residents were affected but all residents had the potential to be affected. The facility replaced the ground fault circuit interrupter (GFCI) to the outside receptacle outlet near the exit door of therapy and replaced the wall fixture in room #215 to ensure no exposed wires. 3. The maintenance director was re-educated on Utilities Equipment. The receptacle outlet testing document has been updated to include outside outlets and will be tested yearly or as needed as well as an updated visual inspection sheet for wall fixtures. 4. As a means of quality assurance, the Maintenance	08/23/2024

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	when tested and the tested. This deficient finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Regional Director of Operations, DON and Administrator all present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 wall light fixtures in room 215 contained a cover and was protected from damage not exposing wires and connections. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 2 residents in room 215 hall. Findings include: Based upon observation and interview with the Maintenance Director (MD) and Administrator during a facility tour on 08/06/24 between 12:40 p.m. and 2:50 p.m., in room #215 which was being used for storage, the light on the wall was missing a cover and wiring was exposed. This deficient finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Regional Director of Operations, DON and Administrator all present. 3.1-19(b)		Director or designee will be responsible to complete Any negative findings will be corrected immediately and reported to the administrator, the GFCI outside outlets have been added to the receptacle outlet document and a new visual inspection sheet will be documented. Any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5 times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.	