STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING -- B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

(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: 07/02/24 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270 At this Emergency Preparedness survey, The Waters of Indianapolis was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 81 certified beds. At the time of the survey, the census was 67. Quality Review completed on 07/08/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	July 20, 2024 Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey on July 2, 2024. Please accept this plan of correction as the provider's credible allegation of compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	. Based on record review and interview, the facility failed to maintain 2 of 2 emergency preparedness plans that were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version and the Maintenance Director's version of "Emergency Preparedness Policy Manual for Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, emergency preparedness program documentation was not reviewed within the most recent twelve month period. The aforementioned plans were dated as being reviewed on 05/15/23 which was not within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director agreed emergency preparedness program documentation was not documented as being reviewed within the most recent twelve month period at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference.	E 0004	1 The Administrator/DON/Maintenance Supervisor/designee updated the emergency preparedness program and reviewed the plan with all staff to meet set standards. 2 All residents and all staff and visitors have the potential to be affected but none were. 3 The Administrator inserviced the DON /Maintenance Supervisor on the requirement to update and review the emergency preparedness program annually to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program. a Maintenance Supervisor/DON/ designee will work with the Administrator to ensure the emergency preparedness program/plan is updated annually and reviewed to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. b The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy	08/10/2024

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			Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator/designee will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.			

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	*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version and the Maintenance Director's version of "Emergency Preparedness Policy Manual for Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed a documented facility-based and community-based risk	E 0006	1 The Maintenance Supervisor, DON and the Administrator updated the emergency preparedness plan that is based on and includes a documented, facility based and community based risk assessment, utilizing an all hazards approach which is reviewed annually and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73 (a) and 42 CFR 483.73(a)2 to meet set standards. 2 All residents and all staff and visitors have the potential to be affected but none were. 3 The Administrator inserviced the Maintenance Supervisor/DON/designee on the requirement that the emergency preparedness plan must include a facility based and community based risk assessment, utilizing	08/10/2024

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	assessment reviewed by the facility within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference.		an all hazards approached and reviewed annually to meet set standards. The Administrator/Maintenance Supervisor/DON inserviced all staff on the updated Emergency Preparedness binders located at the nurses station and all other areas to meet set standards. The Maintenance Supervisor/DON/Administrator/designee will ensure the emergency preparedness plan must include a facility based and community-based risk assessment, utilizing an all hazards approached and reviewed annually to meet set standards. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 The Administrator and Maintenance Supervisor/DON/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator/designee will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components	

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			will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility	E 0013	1 The Maintenance	08/10/2024

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	failed to review and update its emergency preparedness policies annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version and the Maintenance Director's version of "Emergency Preparedness Policy Manual for Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference.		Supervisor/DON/Administrator reviewed and updated the policies and procedures in the emergency plan to meet set standards. 2 All residents and all staff and visitors have the potential to be affected but none were. 3 **T**he Administrator in serviced the DON/ Maintenance Supervisor on the requirement to review and update the policies and procedures in the emergency plan annually to meet set standards. The Administrator or designee inserviced all staff on the updated emergency preparedness program. a The Administrator/Maintenance Supervisor/designee will ensure to review and update the policies and procedures in the emergency plans annually to meet set standards. b The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual to ensure it includes a letter from their natural gas provider to meet set standards. Those reviews will be documented as appropriate. The Administrator/designee will present the training results at the Quality Assurance/ Performance	

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			Improvement (QA/PI) meeting. 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.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version and the Maintenance Director's version of	E 0029	**1** The Administrator and the DON/Maintenance Supervisor/designee reviewed and updated the communications plan in the emergency plan to meet set standards. **2** All residents and all staff and visitors have the potential to be affected but none were. **3** The Administrator inserviced the DON/Maintenance Supervisor/designee on the	08/10/2024

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	"Emergency Preparedness Policy Manual for Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Maintenance Director during the exit conference.		requirement to ensure to update the communications plan in the emergency plan annually to meet set standards. The Administrator inserviced all staff on the updated communication plan. a DON/Maintenance Supervisor/designee will work with the Administrator to ensure to update the communications plan in the emergency plan to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. b The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4** At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator/designee will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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.	

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	155409	A. BUILDING -- B. WING	07/02/2024

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	**1** The Administrator and DON/Maintenance Supervisor/designee reviewed and updated the training and testing program in the emergency preparedness plan to meet set standards.	08/10/2024

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	Findings include: Based on review of the Administrator's version and the Maintenance Director's version of "Emergency Preparedness Policy Manual for Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director agreed the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. These findings were reviewed with the Maintenance Director during the exit conference.		**2** All residents and all staff and visitors have the potential to be affected but none were. **3** The Administrator inserviced DON/Maintenance Supervisor/designee on the requirement to review and update the training and testing program in the emergency preparedness plan to meet set standards. a DON/Maintenance Supervisor/designee will work with the Administrator to ensure to review and update the training and testing program in the emergency preparedness plan to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. b The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4** At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least			

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	every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or			

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion			

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	using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a			

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	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's			

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	response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.			

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	*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.			

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	*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency	E 0039	**1** The Administrator and the DON/ Maintenance	08/10/2024

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	plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version and the Maintenance Director's version of "Emergency Preparedness Policy Manual for		Supervisor/designee conducted a community-based exercise, an individual facility based exercise and an actual natural or man-made emergency that required activation of the emergency plan and documented the results in the Life Safety Binder to meet set standards. **2** All residents and all staff and visitors have the potential to be affected but none were. **3** The Administrator in serviced the DON/ Maintenance Supervisor/designee on the requirement to conduct a community-based exercise, an individual facility-based exercise and an actual natural or man-made emergency that required activation of the emergency plan and document the results in the Life Safety Binder to meet set standards. a DON/Maintenance Supervisor/designee will work with the Administrator to ensure to conduct a community-based exercise, an individual facility-based exercise and an actual natural or man-made emergency that required activation of the emergency plan and document exercises testing the emergency plan at least twice during the year to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. b The Administrator will	

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	Waters of Indianapolis" documentation dated 05/15/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, documentation for a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period was not available for review. The facility also did not document any actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period. Based on interview at the time of record review, the Maintenance Director agreed documentation of a community-based exercise, an individual, facility-based exercise or documentation of an actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period was not available for review. These findings were reviewed with the Maintenance Director during the exit conference.		monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4** At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator/designee will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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.	
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: 07/02/24 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270	K 0000	July 20, 2024 Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

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	At this Life Safety Code survey, The Waters of Indianapolis 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 81 and had a census of 67 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage and a detached smoking shed which were each not sprinklered. Quality Review completed on 07/08/24		required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey on July 2, 2024. Please accept this plan of correction as the provider's credible allegation of compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to install and maintain a door closing coordinator for 1 of 1 door sets to the main Dining Room which are equipped with an astragal per 4.6.12.3. LSC 4.6.12.3 requires existing life safety	K 0100	1 The Maintenance Supervisor/designee installed a coordinator to the entrance to the main dining room to meet set standards.	08/10/2024

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	features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the south door in the corridor door set serving as the entrance to the main Dining Room was equipped with an astragal but the door set was not provided with a door closing coordinator to ensure the door equipped with the astragal always closes last. Each door in the door set was also held in the fully open position with a wall mounted magnetic releasing device set to release with fire alarm system activation. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door set to the main Dining Room was not equipped with a door closing coordinator to ensure the door equipped with the astragal always closes last. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		2 All residents and all staff and visitors have the potential to be affected but none were. 3 The Administrator inserviced the Maintenance Supervisor/designee on the requirement to maintain coordinators for door sets to meet set standards. a Maintenance Supervisor/ designee will ensure to maintain coordinators for door sets as a part of the facility's weekly 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by	

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			the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0222 SS=D 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 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			

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	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 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 corridor doors to 1 of 39 resident sleeping rooms were arranged such that staff can rescue residents in an emergency if the door was locked. This deficient practice could two residents in Room H9. Findings include:	K 0222	1 The Maintenance Supervisor/designee removed the lock from resident sleeping room H9 and installed a passage door lock that had no tool requirements to open it to meet set standards. 2 All residents and all staff and visitors have the potential to	08/10/2024

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	Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the corridor door to resident sleeping Room H9 had a lock on the door handle which could be unlocked from inside the room but required a tool to be inserted into the door handle from the corridor side of the door. The lock on the door was operable. The door handle on the corridor side of the door had a hole in the handle to insert a pin to unlock the door but a pin or tool to unlock the door was not readily available for staff to unlock the door. Based on interview at the time of the observations, the Maintenance Director stated you could insert a paper clip to unlock the door but agreed a pin or tool to unlock the door was not readily available for staff in an emergency if the door became locked. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		be affected but none were. The Maintenance Supervisor/designee inspected all resident room doors and found no other negative findings. 3 The Administrator inserviced the Maintenance Supervisor/designee/ all staff to ensure corridor doors to resident sleeping rooms are arranged such that staff can rescue residents in an emergency. a Maintenance Supervisor/designee will ensure corridor doors to resident sleeping rooms are arranged such that staff can rescue residents in an emergency as a part of the facility's Weekly 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee will present the inspection results at the monthly Quality	

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			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.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			

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	(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure 2 of over 9 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) and trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the following was noted: a. the former Dutch door to the kitchen from the main Dining Room was equipped with a self-closing device and a positive latching device on the door handle but the latching mechanism failed to protrude into the door frame when tested to self-close and latch into the door frame multiple times. The kitchen contained two 32 gallon and one 20 gallon trash carts. b. the latching device on the entry door to the storage room inside the break room had been removed which caused the door to not latch into the door frame when tested to close. The storage room was greater than 50 square feet in size and was used to store combustible boxes and supplies. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two hazardous areas were not separated from other spaces by smoke resistant	K 0321	1 The Maintenance Supervisor/designee repaired the latching mechanism to ensure it self closes and latches into the frame of the dutch door to the kitchen from the main dining room to meet set standards. a The Maintenance Supervisor/designee installed a self closure latching device on the entry door to the storage room to ensure it self closes and latches into the frame to meet set standards. b The Maintenance Supervisor/designee relocated the popcorn popper to a hazard room equipped with a self closing device and positive latching door latch to meet set standards. **2** All residents and all staff and visitors have the potential to be affected but none were. **3** The Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure that all hazardous area doors are provided with a self-closing device to meet set standards. a Maintenance Supervisor/designee will ensure that all hazardous area doors are provided with a self-closing device & latching hardware as a part of	08/10/2024

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	partitions and doors. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn poppers in the Activity room. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Activities Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the Activities Room contained one hot oil popcorn popper which had just been used to pop popcorn. The corridor door to the Activities Room was not equipped with a self-closing device or was not automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the Activities Room was not protected as a hazardous area when a hot oil popcorn popper was being utilized in the room. These findings were reviewed with the Maintenance during the exit conference. 3.1-19(b)		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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4** The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee 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.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is			

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	0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure alcohol based hand sanitizers were not installed over an ignition source in 1 of over 50 rooms. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, an alcohol based hand sanitizer dispenser was installed on the wall	K 0325	**1** The Maintenance Supervisor/designee relocated the alcohol-based hand sanitizer dispensers away from the light switch inside the Laundry Room to meet set standards. **2** All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected the location of all alcohol-based hand sanitizer dispensers and found no other negative findings. **3** The Administrator inserviced the Maintenance Supervisor/designee on the	08/10/2024

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	inside the Laundry Room directly above the light switch for the room by the corridor door. Manufacturer's documentation affixed to the container inside the dispenser stated it contained 70% ethyl alcohol. Based on interview at the time of the observations, the Maintenance Director agreed the dispenser contained an alcohol based solution and agreed the dispenser was installed directly above the light switch for the room. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		requirement that alcohol-based hand sanitizers cannot be installed over ignition sources to meet set standards. a Maintenance Supervisor/designee will inspect all alcohol-based hand sanitizers throughout the facility monthly to ensure they are in the proper locations as a part of the facility's 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4** The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/desginee 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	

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			compliance is maintained.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. NFPA 72, Table 14.4.5 at 15 states fire alarm system initiating devices shall be functional tested annually. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 03/18/24 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, an	K 0345	1 The Maintenance Supervisor/designee reached out to licensed fire alarm contractor and received the proper testing inspection documentation to meet set standards. 2 All residents and all staff and visitors have the potential to be affected but none were. 3 The Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire alarm systems are maintained properly including an itemized list of functional testing of all fire alarm system initiating devices to meet set standards. a Maintenance Supervisor/designee will ensure fire alarm systems are maintained properly including an itemized list of functional testing of all fire alarm system initiating devices as a part of the facility's monthly Preventive	08/10/2024

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	155409	A. BUILDING 01 B. WING	07/02/2024

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	itemized list of functional testing all fire alarm system initiating devices in the facility within the most recent twelve month period was not available for review. The 03/18/24 documentation contained a listing of the results of visual inspections of initiating devices which was dated as 09/18/23. In addition, the review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 09/18/24 also indicated it was a listing of the results of visual inspections of initiating devices which was dated as 09/18/23. Based on interview at the time of record review, the Maintenance Director stated additional fire alarm inspection and testing documentation within the most recent twelve month period was not available for review. The Maintenance Director contacted the fire alarm system inspection contractor during record review to provide 03/18/24 testing documentation but the contractor again provided the results of the visual inspection of initiating devices dated 09/18/24 for the cover page of the report dated 03/18/24. Based on interview at the time of record review, the Maintenance Director agreed an itemized list of functional testing all fire alarm system initiating devices in the facility within the most recent twelve month period was not available for review. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee 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.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Work Performed"	K 0353	**1** The facilities licensed sprinkler contractor repaired the sprinkler system per the 8/10/23 inspection documentation and received copy of the completed repair work to meet set standards. a The Maintenance Supervisor/designee sealed the holes with a one hour fire rated material in the corridor ceiling outside room H9 and in the ceiling in the bathroom for resident room L11 to meet set standards. **2** All residents and all staff and visitors have the potential to be affected but none were. **3** The Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to maintain the sprinkler systems including correcting any deficiencies noted and to ensure to maintain the ceiling construction in ceiling	08/10/2024

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	documentation dated 08/10/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, the facility's automatic sprinkler system needs additional repairs. The "Further Work Required" section of the 08/10/23 inspection documentation stated "send quote to replace 1/4" bleed off valve (Gate Valve) connected to alarm pressure switch & alarm test valve. 1/4" nipple connected to 1/4" gate valve broke off into tee during sprinkler inspection. Also replace 1/4" gate valve on feeding water gauge." Based on interview at the time of record review, the Maintenance Director stated he could not find the quote for sprinkler system repair and agreed he was not certain the sprinkler system repairs were made on or after 08/10/23. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the facility had one supervised dry sprinkler system riser located in the maintenance office. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents,		smoke barriers to meet set standards. a Maintenance Supervisor/designee will ensure to maintain the sprinkler systems including correcting any deficiencies noted and to ensure to maintain the ceiling construction in ceiling smoke barriers as a part of the facility's quarterly 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4** The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee 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	

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	staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, four separate holes were noted in the corridor ceiling outside Room H9 which exposed the attic above. In addition, a one inch in diameter hole was noted in the ceiling in the bathroom for resident Room L11 which exposed the attic above. Based on interview at the time of the observations, the Maintenance Director stated a lighting fixture used to be in place on the ceiling outside Room H9 and agreed the holes in the ceiling at the aforementioned two locations did not maintain the ceiling construction. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		compliance is maintained.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A,	K 0521	**1** The facility's licensed contractor inspected the three fire dampers and received copies of the inspection to file in the facilities life safety binder to meet set standards. **2** All residents and all staff and visitors have the potential to be	08/10/2024

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	Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire Damper Inspection Checklist" documentation dated June 2023 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, a total of 115 fire dampers in the facility were inspected and tested within the most recent four year period. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the fire damper inspection contractor had affixed inspection stickers to fire damper locations throughout the facility which were dated June 2023 to most all fire damper locations except three fire damper locations. Each of the three fire damper locations		affected but none were. **3** The Administrator inserviced the Maintenance Supervisor/designee on the requirement to test all fire dampers to meet set standards. a Maintenance Supervisor/designee will inspect and test all fire dampers as required as a part of the facility's 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4** The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee 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 insure	

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	had an affixed inspection sticker which was dated 06/19/24. The three fire damper locations were in the corridor ceiling outside Room H10, at the entrance to the Faith Hall and outside the Administrator's office. The three fire damper locations could not be identified on the contractor's June 2023 inspection documentation. Based on interview at the time of the observations, the Maintenance Director agreed it could not be ensured the aforementioned three fire damper locations were inspected and tested within the most recent four year period. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		compliance is maintained.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than	K 0761	1 The Maintenance Supervisor/designee conducted the annual inspection for the fire door inspections including the doors to oxygen storage and transfilling rooms and documented the inspection results on the Annual Door Inspections log to meet set standards. 2 All residents and all staff and visitors have the potential to be affected but none were. 3 The Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing and inspections of the fire door assemblies including the doors to oxygen storage and	08/10/2024

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	annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include:		transfilling rooms must be conducted to ensure proper operation and documented on the Annual Door Inspections log to meet set standards. a Maintenance Supervisor/designee will conduct the annual inspection of fire door assemblies including the doors to oxygen storage and transfilling rooms to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's 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. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator/designee will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by	

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	Based on review of "Annual Fire Door Inspection" documentation dated 11/21/23 with the Maintenance Director during record review from 9:05 a.m. to 12:20 p.m. on 07/02/24, annual fire door inspections for the facility did not include doors to oxygen storage and transfilling rooms. Based on interview at the time of the review, the Maintenance Director stated he did not inspect and test doors to oxygen storage and transfilling rooms and agreed documentation of annual inspection and testing for the oxygen storage and transfilling rooms within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 07/02/24, the corridor door to the oxygen storage and transfilling room across from the main Dining Room was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. The oxygen storage and transfilling room contained four liquid oxygen containers and nine 'E' type oxygen cylinders. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	