Jerod Williams

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

10/09/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0000	conducted by the In accordance with 42 Survey Date: 09/26 Facility Number: 0 Provider Number: 100 At this Emergency Waters of Covingto compliance with Er Requirements for M Participating Provided 483.73.	00128 155223 289650 Preparedness survey, The n was found not in nergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR	E 0000		
E 0039 SS=F Bldg	403.748(d)(2), 410 441.184(d)(2), 483 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requii §416.54(d)(2), §46 §460.84(d)(2), §46 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2) *[For ASCs at §41 OPO, "Organization CMHCs at §485.9	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d), , §494.62(d)(2). 6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at	GNATURE	TITI F	(X6) DATE
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155223	B. W	ING		09/26/	/2023
NAME OF D	DOWNED OF CHIRD IEE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF				LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVING	GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	§491.12, and ESF 	RD Facilities at §494.62]:					
	(2) Testing The If	acility) must conduct					
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:						
	9						
	(i) Participate in a	full-scale exercise that is					
	community-based	- ·					
	` '	nunity-based exercise is					
		nduct a facility-based					
		e every 2 years; or					
	, , -	ility] experiences an actual ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
		or individual, facility-based					
	-	e following the onset of the					
	actual event.	3					
	(ii) Conduct an ad	ditional exercise at least					
	every 2 years, opp	posite the year the full-scale					
		cise under paragraph (d)(2)					
	` '	s conducted, that may					
		limited to the following:					
	• •	scale exercise that is					
	functional exercise	or individual, facility-based					
	(B) A mock disast	•					
		ercise or workshop that is					
	, ,	and includes a group					
	discussion using a	- -					
		emergency scenario, and a					
	set of problem sta						
	•	pared questions designed					
	to challenge an er	nergency plan.					
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					

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	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223		JILDING	NSTRUCTION	(X3) DATE COMPL 09/26/	ETED	
	F PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based functional of the emergency exempt from engay scale community-facility-based functional exercise of the emer (ii) Conduct an advers, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disass (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an energy of the care directly. The exercises to test to per year. The hose	spices that provide care in e. The hospice must so to test the emergency sally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not let an individual facility exercise every 2 years; or experiences a natural or lency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Inditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is lor a facility based le; or leter drill; or lercise or workshop that is and includes a group a narrated, emergency scenario, and a litements, directed pared questions designed						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155223 B. WING		NSTRUCTION	(X3) DATE (COMPL 09/26/	ETED		
	PROVIDER OR SUPPLIER		1600 E	NDDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accessible, condu- facility-based func (B) If the hospice man-made emerg of the emergency exempt from enga full-scale commun functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full- community-based functional exercise (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the h maintain documer exercises, and em the hospice's emergency	nunity-based exercise is not lect an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based at following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based at or a facility based at a group discussion clinically-relevant rio, and a set of problem and messages, or prepared and to challenge an espice's response to and intation of all drills, tabletop mergency events and revise ergency plan, as needed.				
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII			COMPL	
		155223	B. WIN	G		09/26/	2023
NAME OF F	PROVIDER OR SUPPLIER	• }			DDRESS, CITY, STATE, ZIP COD		
					LIBERTY ST		
WATERS	OF COVINGTON,	THE		COVING	GTON, IN 47932		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		ct an annual individual,					
		tional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency is exempt from engaging in					
		ull-scale community based					
	-	ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	` '	an [additional] annual at may include, but is not					
	limited to the follow						
		scale exercise that is					
	community-based						
		ctional exercise; or					
		ck disaster drill; or					
	, ,	exercise or workshop that					
		or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta	- ·					
		pared questions designed					
	to challenge an er	·					
	_	he [facility's] response to					
	, ,	umentation of all drills,					
		s, and emergency events					
	-	cility's] emergency plan, as					
	needed.	, , , , , , , , , , , , , , , , , , , ,					
	*[Ear DACE at \$46	30 84(d)·1					
	*[For PACE at §46	· / -					
	. ,	ACE organization must					
	plan at least annu	to test the emergency					
	organization must	_					
	_	an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
	, ,	ict an annual individual,					
		ctional exercise; or					
	I -	xperiences an actual natural					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2023				
		ROVIDER OR SUPPLIER OF COVINGTON,		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		activation of the eis exempt from en full-scale community-based functional exercise of this section is country based functional exercise of this section is country based functional exercise of this section is country based based functional exercise (A) A second full-community-based based functional exercise (B) A mock disass (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an ere (iii) Analyze the Proposition of the PACE's emergency exercises, and emergency exercises, and emergency proposition of the emergency p	n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) onducted that may include, o the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. PACE's response to and ntation of all drills, tabletop mergency events and revise gency plan, as needed. Les at §483.73(d):] ty] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: an annual full-scale exercise abased; or aunity-based exercise is not oct an annual individual,						

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	PROVIDER OR SUPPLIEIS			1600 E I	DDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	(X5) COMPLETION
PREFIX TAG	requires activation LTC facility is exerequired a full-scalindividual, facility- following the onset (ii) Conduct an activation and that may include, following: (A) A second full-community-based based functional activation and facility-relevant set of problem stares and revise emergency plan, and the following: *[For ICF/IIDs at & (2) Testing. The Idex exercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (B) If the ICF/IID activation of the exercises of the exercises function and facility-based function activation of the exercise in the exercises function and facility-based function activation of the exercise in the exercises function and facility-based function activation of the exercise in the exercise function and facility-based function activation of the exercise in the exercise function of the exercise activation activation of the exercise activation activatio	a community-based or based functional exercise but is not limited to the exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. S483.475(d)]: CF/IID must conduct the emergency plan at least ne ICF/IID must do the exercise is not an annual full-scale exercise is not act an annual individual, ctional exercise; or experiences an actual ade emergency plan, the ICF/IID designed emergency plan, annual individual, ctional exercise; or experiences an actual ade emergency plan, the ICF/IID		TAG TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ATE	DATE
		ngaging in its next required nity-based or individual,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIER		•	1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ctional exercise following the		1110			DiffE
	onset of the emer	_					
		ditional annual exercise					
	, , ,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
		ercise or workshop that is					
		and includes a group					
	discussion, using	emergency scenario, and a					
	set of problem sta	•					
		pared questions designed					
	to challenge an e	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	` ' ' '	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	&.II					
		full-scale exercise that is					
	community-based	ommunity-based exercise					
	` '	conduct an annual					
		based functional exercise					
	every 2 years; or.						
		A experiences an actual					
	' '	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from enga	aging in its next required					
		nity-based or individual,					
	1	tional exercise following the					
	onset of the emer						
	(ii) Conduct an ad	ditional exercise every 2					

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155223	 UILDING	nstruction 	COMPI 09/26	LETED
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD LIBERTY ST		
WATERS	S OF COVINGTON,	THE		GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE
		e year the full-scale or e under paragraph (d)(2)(i)				
	of this section is c					
		limited to the following:				
		full-scale exercise that is				
	community-based					
	facility-based fund					
	I	isaster drill; or				
	, ,	exercise or workshop that				
		or and includes a group				
	discussion, using	a narrated,				
	clinically-relevant	emergency scenario, and a				
	set of problem sta	tements, directed				
		pared questions designed				
	to challenge an er					
		HA's response to and				
		ntation of all drills, tabletop				
		nergency events, and revise				
	the HHA's emerge	ency plan, as needed.				
	*[For OPOs at §48	36.360]				
		e OPO must conduct				
		he emergency plan. The				
	OPO must do the	•				
		er-based, tabletop exercise				
		ast annually. A tabletop				
		a facilitator and includes a				
		using a narrated, clinically				
		cy scenario, and a set of				
		its, directed messages, or is designed to challenge an				
	1 ' ' '	f the OPO experiences an				
		nan-made emergency that				
		of the emergency plan, the				
		om engaging in its next				
	· · · · · · · · · · · · · · · · · · ·	xercise following the onset				
	of the emergency	——————————————————————————————————————				
		PO's response to and				
		ntation of all tabletop				
		nergency events, and revise				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIEF		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	reeded. *[RNCHIs at §403 (d)(2) Testing. The exercises to test to the state of the exercises to test to the state of the exercises to test to the state of the emergency product a paper of the emergency product of the actual to the state of the emergency product of the emergency product of the emergency product of the content of the actual to the state of the actual to the state of the emergency product of the emergency product of the emergency product of the content of the actual to the onset of the actual to the state of the	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. riew and interview, the facility nercises to test the emergency per year, including drills using the emergency re facility must do the annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based I exercise for I year following table to the following:	E 0039	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepar and/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegatio of substantial compliance wi Federal Medicare and Medicaid requirements.	the set red ce	

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community-based or an individual, facility-based

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facility to ensure to conduct

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	RTMENT OF HEALTH AND HUMAN SERVICES TERS FOR MEDICARE & MEDICAID SERVICES						RM APPROVED B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	COMPLETED	
AND PLAN	OF CORRECTION	155223				09/26/2023	
		199223	B. WING			09/26/	72023
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	KO VIDEK OK SOTT EIEI			1600 E	LIBERTY ST		
WATERS	OF COVINGTON,	THE	COVINGTON, IN 47932		GTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	functional exercise.				exercises to test the emergen	су	
	b. A mock disaster	drill; or			plan at least twice per year,		
	c. A tabletop exerci	se or workshop that is led by a			including unannounced staff of	drills	
	facilitator that inclu	ides a group discussion, using			using the emergency procedu	ıres	
	a narrated, clinicall	y relevant emergency scenario,			to meet set standards.		
	and a set of probler	n statements, directed			1 CORRECTIVE ACTION	S	
	messages, or prepar	red questions designed to			TAKEN:		
	challenge an emerg	ency plan.			a On 10/2/2023 the		
	(iii) Analyze the L7	TC facility's response to and			Administrator and the		
	maintain document	ation of all drills, tabletop			Maintenance Supervisor/design	gnee	
		gency events, and revise the			conducted a full scale drill that	_	
		gency plan, as needed in			community based or an indivi	dual.	
	_	CFR 483.73(d)(2). This			facility-based functional exerc		
		ould affect all occupants.			a mock disaster drill or works		
	•	•			that is led by a facilitator that	•	
	Findings include:				includes a group discussion,		
					a narrated, clinically relevant	3	
	Based on review of	the facility's Emergency			emergency scenario, and a se	et of	
		on 09/26/23 at 1:28 p.m.,			problem statements, directed		
	_	table top drill was available for			messages, or prepared quest	ions	
		ity could not provide			designed to challenge an		
		a full-scale exercise that is			emergency plan to meet set		
		or an individual, facility-based			standards.		
		a mock disaster drill, or			2 ALL OTHERS WITH		
		d by a facilitator that includes a			POTENTIAL TO BE AFFECT	FD·	
		sing a narrated, clinically			a All residents and all staf		
		scenario, and a set of problem			and visitors have the potentia		
		l messages, or prepared			be affected but none were.	110	
	· ·	to challenge an emergency			3 MEASURES TO PREVE	NT	
		rview at the time of record			REOCCURRENCE:		
	_	nance Director agreed that			a On 9/27/2023 the		
		drill or exercise could not be			Administrator in-serviced the		
		as of the time of this survey.			DON/Maintenance		
	13cated 101 1c view 8	as of the time of this survey.			Supervisor/designee on the		
	This finding was re	viewed with the facility			requirement to ensure to cond	duct	
	_	ntenance Director, and the			exercises to test the emergen		
		personnel during the exit			plan at least twice per year,	Юу	
	regional rioperty	personner during the CAIL	1		pian acicasi (wice per year,		I

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conference.

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including unannounced staff drills using the emergency procedures

to meet set standards.

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023	
	ROVIDER OR SUPPLIE		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST IGTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORI O			b DON/Maintenance Supervisor/designee will work the Administrator to ensure to conduct exercises to test the emergency plan at least twice year, including unannounced drills using the emergency procedures to meet set standards. If any issues are discovered, they will be addre and resolved immediately, c The Administrator will monitor adherence to the Emergency Preparedness Po Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a At least annually to ens compliance, the Administrato DON/Maintenance Supervisor/designee will revir Emergency Preparedness Po Manual and conduct required exercises and make changes necessary to meet set standa Those reviews will be docum as appropriate. The Administ will present the training result the Quality Assurance/ Performance Improvement (O meeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible	k with be per staff essed blicy ure or and ew the blicy i sas ards. ented rator ts at QA/PI) n by on as

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Event ID:

XRFK21 Facility ID: 000128

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		A. BUILDING B. WING		COME	COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP LIBERTY ST IGTON, IN 47932	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				allegation of complia all regulatory require Our date of complian 10/2/2023.	ements.	
E 0041 SS=C Bldg	§482.15(e) Conditi (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this set (ii) and (iii) of this set (ii) and (iii) of this set (iii) and (iii) of this set (iii) and (iii) of this set (iiii) and (iii) of this set (iii) and	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Indicate the CAH] must ency and standby power the emergency plan set (a) of this section. 63.73(e)(1), §485.625(e)(1) experiments found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	requirements foun	, and [maintenance] d in the Health Care FPA 110, and Life Safety				
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency erational during the s it evacuates.				
	§483.73(g), and Company The standards incompany this section are appreference by the Expedience by the Standard Boulevard, Baltimore and Recompany the Expedience by the Exped	price Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are ference, CMS will publish a ederal Register to inges.				
	, ,	ch Care Facilities Code, ed August 11, 2011.				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPI A. BUILDIN B. WING	(X3) DATE SURVEY COMPLETED 09/26/2023				
	F PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	NFPA 99, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NI 22, 2013. (xii) NFPA 110, S Standby Power S including TIAs to 2009. Based on record refailed to implement inspection, testing, found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all occupants Findings include: Based on record red Director on 09/26/2 the facility did not it gas provider indicate reliable source. Base	FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012 gust 11, 2011. IFPA 101, issued August FPA 101, issued October	E 0041	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepand/or executed in complia with state and federal laws. This plan of correction constitutes a written allegation.	on ot of the as set ared ance		

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIE S OF COVINGTON		1600 E	ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST IGTON, IN 47932	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) BE COMPLETION DATE
				of substantial compliance Federal Medicare and Medicaid requirements.	with
	survey. This finding was re	eviewed with the Administrator, tor and Regional Property		E041– It is the intent of the to ensure to implement the emergency power system inspection, testing and maintenance requirements in the Health Care Facilities NFPA 110, and Life Safety in accordance with 42 CFR (e)(2) to meet set standards 1 CORRECTIVE ACTIO TAKEN: a On 9/27/2023 the Maintenance Supervisor/Administrator ob a letter from their natural gaprovider indicating the naturi is from a reliable source and documented the information facilities Life Safety Binder to meet set standards. 2 ALL OTHERS WITH POTENTIAL TO BE AFFEC a All residents and all stand visitors have the potent be affected but none were. 3 MEASURES TO PREVIOLED REOCCURRENCE: a On 9/27/2023 the Administrator in-serviced the Maintenance Supervisor/de on the requirement to have from their natural gas providindicating the natural gas is reliable source on file to me standards. b The Maintenance	found Code, Code 483.73 5. NS stained s ral gas d n in the to TED: aff ial to VENT e signee a letter der from a

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLI	
		155223					
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF COVINGTON,	THE			LIBERTY ST GTON, IN 47932		
					I		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		TE	COMPLETION DATE	
					Supervisor/designee will ensu	re to	
					have a letter from their natural		
					provider indicating the natural	gas	
					is from a reliable source on file	e to	
					meet set standards.		
					c The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol Manual and validate the	icy	
					documentation is in place.		
					4 MONITORING		
				CORRECTIVE ACTION:			
				a The Administrator and			
					Maintenance Supervisor/desig	nee	
					will review the Emergency		
					Preparedness Policy Manual t	О	
				ensure it includes a letter from			
					their natural gas provider to m		
					set standards. Those reviews		
					be documented as appropriate		
					The Administrator will present training results at the Quality	trie	
					Assurance/ Performance		
					Improvement (QA/PI) meeting		
					Results and system componer		
					will be reviewed by the QA/PI		
					Committee with subsequent pl	lans	
					of correction developed and		
					implemented as deemed		
					necessary to ensure complian	ce	
					is maintained.		
					This plan of correction constitutes our credible		
					allegation of compliance with	,	
					all regulatory requirements.	•	
					Our date of compliance is		
					9/27/2023.		
K 0000							
			1		I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155223		A. BUILDING <u>01</u> B. WING			COMPLETED 09/26/2023	
		100220						
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LIBERTY ST			
WATERS	OF COVINGTON,	THE			GTON, IN 47932			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/26 Facility Number: 0 Provider Number: 1002 At this Life Safety 0	00128 155223 289650 Code survey, The Waters of	K 0	000				
	Covington 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 119 and had a census of 94 at the time of this visit.							
	were sprinkled and services were sprink	dents have customary access all areas providing facility cled except for two detached detached Garage which were appleted on 09/27/23						
K 0300 SS=E	NFPA 101 Protection - Other							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155223		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/26/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) COMPLETION DATE	
Bldg. 01	Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included 1. Based on observation failed to ensure all be in resident rooms who will be included 1. Based on observation failed to ensure all be in resident rooms who will be included 1. Based on observation failed to ensure all be in resident rooms who will be seen to the public, if not maintained. NFPA Signaling Code, 20 fire-warning equipment ested in accordance published instruction of Chapter 14. Sect testing, and mainter the requirements of equipment manufact Section 14.4.8.1 stare commended by the instructions, singlealarms shall be replied to operability tests belonger than 10 years. This deficient practice staff, and visitors. Findings include: Based on observation with the Maintenant 10:04 a.m. to 11:45 smoke alarms in resident practice with the Maintenant 10:04 a.m. to 11:45 smoke alarms in resident practice.	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, don Form CMS-2567. In the addressed smoke alarms are maintained. NFPA 101 in ing life safety features obvious required by the Code, shall be 72, National Fire Alarm and 10 Edition, Section 29.10 states and per the requirements are manufacturer's published instructions. It is unless otherwise and multiple-station smoke and multiple-station smoke and multiple-station smoke and multiple-station smoke are dwhen they fail to respond out shall not remain in service is from the date of manufacture. It is could affect all residents, and the battery operated and multiple at the state of manufacture. It is could affect all residents, and the battery operated and multiple	K 0300	DISCLAIMER STATEMEN' Preparation and/or execute of this plan of correction is general, or this corrective action in particular, does constitute an admission of agreement by this facility facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are pre and/or executed in comple with state and federal law This plan of correction constitutes a written alleg of substantial compliance Federal Medicare and Medicaid requirements. K300— It is the intent of the to ensure all battery-operat smoke alarms in resident re are maintained and to ensu documentation for the prev maintenance of battery-ope smoke alarms in resident re complete to meet set stand 1 CORRECTIVE ACTIO TAKEN: a On 10/9/2023 the Maintenance Supervisor/de	tion in not or of the ons set pared iance s. gation with facility ted ooms ure rentative erated ooms is dards. UNS	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2023 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE alarms and that they are to be replaced after 10 replaced the battery-operated years. The Maintenance Director stated he has smoke alarms, including the been installing newer battery operated smoke batteries, in resident rooms 48 & alarms in resident rooms when they have failed. 22 that had manufacture dates of During the tour of the facility, there were two 7-20-05 and checked all other different models of battery operated smoke alarms battery powered smoke alarms in installed in resident rooms. The Maintenance the building and replaced any Director stated about half of the 69 resident rooms others that were not meeting had the model of smoke alarms installed with the manufacturer's guidelines to meet July 20, 2005 manufacture date. set standards. The Administrator verified the work on 10/9/2023. This finding was discussed with Administrator, On 9/27/2023 the Maintenance Director and Regional Property Administrator inserviced the personnel at the exit conference. Maintenance Supervisor/designee on the requirement that all 2. Based on record review, interview and battery-operated smoke detectors observation, the facility failed to ensure must be tested per manufacture's documentation for the preventative maintenance guidelines and documentation of 69 of 69 battery operated smoke alarms in retained at the facility to meet set resident rooms was complete. NFPA 101 in standards. 4.6.12.3 states existing life safety features obvious On 10/9/2023 the to the public, if not required by the Code, shall be Maintenance Supervisor/designee maintained. NFPA 72, 29.10 Maintenance and tested all battery-operated smoke Tests. Fire-warning equipment shall be maintained detectors including room 42 and and tested in accordance with the manufacturer's documented the results in the published instructions and per the requirements facilities Life Safety Binder to of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, meet set standards. The testing, and maintenance programs shall satisfy Administrator verified the work on the requirements of this Code and conform to the 10/9/2023. equipment manufacturer's published instructions. **ALL OTHERS WITH** This deficient practice could affect all residents, POTENTIAL TO BE AFFECTED: staff, and visitors. All residents and all staff and visitors have the potential to Findings include: be affected but none were. **MEASURES TO PREVENT** Based on review of the Battery Operated Smoke REOCCURRENCE: Detector Maintenance Logs on 09/26/23 from Maintenance 11:48 a.m. to 1:52 p.m. with the Maintenance Supervisor/designee will ensure all Director present, the resident room battery battery-operated smoke alarms operated smoke alarms were tested on a monthly are maintained and tested per

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/26/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE	
	observation with the a tour of the facility detector located in model i9050 manuf weekly testing. Bas review and observa stated that all batter the facility are teste manufacturers instractor with the facility are teste manufacturers instractor with the facility are tested manufacturers in the facility are teste	t twelve months. Based on a Maintenance Director during to the battery operated smoke resident room #42 was a Kidde factured May 2017 and requires and on interview at the time of tion, the Maintenance Director y-operated smoke detectors in dimonthly and confirmed that factions of the one in resident are weekly testing. The for stated he has installed the early operated smoke detector as a resident rooms as the older lifterent detectors. The fact of the fact of the stated he would start as required by manufacture's wiewed with the Administrator, for and Regional Property the conference.		manufactures guidelines ar document the results on the Battery-Operated Smoke D Maintenance Log to be filed Life Safety Binder as a part facility's Preventive Mainten Program. If any issues are discovered, they will be add and resolved immediately. Maintenance Supervisor/de will review with the Administ the inspection results. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results be presented by the Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results be presented by the Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results be presented by the Maintenance documentation will present the supervisor/designee to the Administrator will present the supervisor results at the monography of the previous threshold in the previous threshol	etector d in the of the hance dressed The esignee strator de the hance		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155223	B. W	B. WING 09/2			2023	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)	
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
					10/9/2023.			
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure						
Bldg. 01	Hazardous Areas							
		are protected by a fire						
		our fire resistance rating						
	(with 3/4 hour fire	rated doors) or an						
		nguishing system in						
		3.7.1 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						
		and permitted to have						
	-	applied protective plates that						
		inches from the bottom of						
	the door.							
	Describe the floor	and zone locations of						
	hazardous areas t	hat are deficient in						
	REMARKS.							
	19.3.2.1, 19.3.5.9							
	Area Separation	Automatic Sprinkler						
	•	-Fired Heater Rooms						
		er than 100 square feet)						
		nance, and Paint Shops						
	-	ooms (exceeding 64						
	gallons)	,						
	e. Trash Collection	n Rooms						
	(exceeding 64 gal	lons)						
		orage Rooms/Spaces						
	(over 50 square fe	,						
	,	classified as Severe						
	Hazard - see K32	,		221			10/00/2022	
		on and interview, the facility	K 0	321	DISCLAIMER STATEMENT:	_	10/09/2023	
		f 1 filing room with a large			Preparation and/or execution	1		
	amount of combusti	ble storage and greater than			of this plan of correction in			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>01</u>			COMPLETED	
		155223	B. W	ING		09/26/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
VA/A TEDO	OF COMMOTON	THE			LIBERTY ST		
WATERS	OF COVINGTON,	THE	COVINGTON, IN 47932				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROJUDENCE N. AN OF CORRESPOND			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
50 square feet was protected as a hazardous area.				general, or this corrective			
	This deficient pract	ice could affect 10 residents in			action in particular, does not	t	
	_	n Wing nurse station.			constitute an admission or		
		6			agreement by this facility of	the	
	Findings include:				facts alleged or conclusions		
	1 mumgs meruuer				forth in this statement of	001	
	Based on observation	on during a tour of the facility			deficiencies. The plan of		
		ce Director on 09/26/23 at 1:30			correction and specific		
		n, located across the corridor			corrective actions are prepar	rad	
		g nurse station contained over			and/or executed in complian		
		-			with state and federal laws.	Ce	
	50 plastic boxes full of paper files, 5 filing cabinets						
	and was greater than 50 square feet making this a hazardous area. The filing room was not protected				This plan of correction		
		because the corridor door to			constitutes a written allegati		
					of substantial compliance wi	tn	
		quipped with a self closing			Federal Medicare and		
		terview at the time of			Medicaid requirements.		
		nintenance Director agreed the					
	_	ed a large amount of			K321– It is the intent of the fac	-	
	_	e, was larger than 50 square			to ensure filing room with a lar	-	
		or door to the room did not			amount of combustible storage		
	have a self-closing	device.			and greater than 50 square fe		
					protected as a hazardous area	a to	
		viewed with the Administrator,			meet set standards.	_	
		rector and Regional Property			1 CORRECTIVE ACTIONS	3	
	personnel during the	e exit conference.			TAKEN:		
					a On 9/27/2023 the		
	3.1-19(b)				Maintenance Supervisor/desig	-	
					installed a self-closing device		
					the filing room door to meet se	∍t	
					standards. The Administrator		
					verified the work on 10/9/2023	3.	
					2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTE	ED:	
					a All residents and all staff	f	
					and visitors have the potential	to	
					be affected but none were.		
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a On 9/27/2023 the		
					Administrator in-serviced the		
			1		1		l

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPI 09/26	LETED
	ROVIDER OR SUPPLIE		1600 E	ADDRESS, CITY, STATE, ZIP CO LIBERTY ST GTON, IN 47932	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				Maintenance Supervisor on the requirement to e hazardous areas are edwith a self-closing device set standards. b Maintenance Supervisor/designee wire all hazardous area door they have a self-closing a part of the facility's more preventive Maintenance and document those instresults as appropriate. Issues are discovered, addressed and resolved immediately. The Maintenance and document those instresults as appropriate. Issues are discovered, addressed and resolved immediately. The Maintenance and documentation. The Maintenance and the Administrator the Administrator the Inspection results. c The Administrator the Preventative Maintenance and validate the Preventative Maintenance and documentation is in place and the Inspection results and the Inspection results at the Quality Assurance/Performerovement (QA/PI) more inspection results at the Quality Assurance/Performerovement (QA/PI) more components will be revithe QA/PI Committee we subsequent plans of condeveloped and implements.	Il inspect sto ensure device as conthly e Program spection of any they will be determined by the store of the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIE		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST IGTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10/9/2023.	h
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of syster inspection and tes secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any	supply source RKS information on non-required or partial			
	failed to ensure 1 of provided with spart cabinet and a sprin NFPA 25, Standard and Maintenance of Systems, 2011 Edit supply of spare springshall be maintained	-	K 0353	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of	t the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	ETED
		155223	B. WING			09/26/2023	
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
\\/ATED		TUE			LIBERTY ST		
WATERS	OF COVINGTON,	INC		OVINC	GTON, IN 47932		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
		mptly replaced. The sprinklers			correction and specific		
	_	the types and temperature			corrective actions are prepar	ed	
	ratings of the sprinklers on the property. The				and/or executed in compliand	ce	
	_	cept in a cabinet located where			with state and federal laws.		
	_	which they are subjected will at			This plan of correction		
		degrees Fahrenheit. A special			constitutes a written allegation	on	
	*	all be provided and kept in the			of substantial compliance wit	th	
		n the removal and installation			Federal Medicare and		
	of sprinklers. This deficient practice could affect				Medicaid requirements.		
	all residents and sta	Iff in the facility.					
					K353 – It is the intent of the		
	Findings include:				facility to ensure to document		
					sprinkler systems are provided		
		ons and interview during a			with spare sprinklers, a spare		
	-	with the Maintenance Director			sprinkler cabinet and a sprinkle	er	
		8 a.m., there was one spare			wrench on the premises and to)	
	_	the riser room. Six spare			ensure sprinkler heads in the		
	_	ing loose in the box and five			facility are not loaded or cover	ed	
		ders. Based on interview at the			with foreign material in accorda	ance	
		tion, the Maintenance Director			with LSC 9.7.5 to meet set		
		rinkler cabinet had spare			standards.		
	sprinklers not in pro	otected slots.					
					1.CORRECTIVE ACTIONS		
	_	viewed with the Administrator,			TAKEN:		
		tor and Regional Property			1.On 10/5/2023 the		
	personnel at the exi	t conference.			Maintenance Supervisor/desig		
					secured the six spare sprinkler		
		ation and interview, the facility			protected slots that were sitting	9	
	_	inkler heads in the facility were			loose in the box to meet set		
		ed with foreign material in			standards. The Administrator		
		SC 9.7.5. NFPA 25, 2011 edition,			verified the work on 10/9/2023		
	•	ers shall not show signs of			2.On 10/5/2023 the faciliti	es	
	_	ee of corrosion, foreign			certified sprinkler contractor		
		d physical damage; and shall			ordered the sprinkler heads in	the	
		orrect orientation (e.g.,			1. housekeeping closet by		
		or sidewall). Furthermore, at			resident room 50 that was gree	en in	
		tler that shows signs of any of			color and showing signs of		
	the following shall be replaced: (1) Leakage (2)		- [corrosion 2. In the housekeepi	ng	

Corrosion (3) Physical Damage (4) Loss of fluid in

the glass bulb heat responsive element (5)

closet by Fountain wing nurse

station that was green in color and

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2023 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Loading (6) Painting unless painted by the showed signs of corrosion to meet sprinkler manufacturer. This deficient practice set standards. The Administrator could affect staff and up to 8 residents. verified sprinklers were ordered on 10/9/2023. Findings include: 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED: Based on observations and interview during a 1.All residents and all staff tour of the facility with the Maintenance Director and visitors have the potential to on 09/26/23 between 10:04 a.m. and 11:45 a.m., the be affected but none were. following was noted: **3.MEASURES TO PREVENT** 1) the sprinkler head in the housekeeping closet REOCCURRENCE: by resident room 50 was green on color and 1.On 9/27/2023 the showed signs of corrosion. Administrator in-serviced the 2) the sprinkler head in the housekeeping closet Maintenance Supervisor/designee by Fountain Wing nurse station was green in on the requirement that the spare color and showed signs of corrosion. sprinkler heads must be in protected slots and the sprinkler This finding was reviewed with the Administrator, heads must be maintained and not Maintenance Director and Regional Property loaded or covered with corrosion to personnel at the exit conference. meet set standards. 2.Maintenance 3.1-19(b)Supervisor/designee will ensure the spare sprinkler heads must be in protected slots and the sprinkler heads must be maintained and not loaded or covered with corrosion as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.

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3.The Administrator will

monitor adherence to the Preventative Maintenance schedule and validate the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Preventative Maintenance documentation is in place.		(X5) COMPLETION DATE
IV 0000					4.MONITORING CORRECTIVACTION: 1.The inspection results we be presented by the Maintenar Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed be the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is by 10/27/2023.	vill nce ally ne	
K 0363 SS=D Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in the for at least 20 fully sprinklered smoke enonly required to resist the end. Corridor doors and doors					

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to rooms containing flammable or

combustible materials have positive latching

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST IGTON, IN 47932	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	CMS regulation. Tapply to auxiliary signammable or come Clearance between covering is not exceed on the door closed with a complete of the door closed with a complete of the door closed with a complete of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated the materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,			
	Based on observation failed to ensure 1 of doors were provided keeping the door closing, latching an	on and interview, the facility f 69 resident room corridor d with a means suitable for osed, had no impediment to d would resist the passage of ent practice could affect 2	K 0363	DISCLAIMER STATEMENT: Preparation and/or executio of this plan of correction in general, or this corrective action in particular, does no constitute an admission or agreement by this facility of	t the
	Findings include:	on with the Maintenance		facts alleged or conclusions forth in this statement of deficiencies. The plan of	. 261
	Based on observation with the Maintenance			correction and specific	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<u>01</u>	COMPLETED
		155223	B. WI	NG		09/26/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OE CORDECTIONI	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	Director on 09/26/2	3 during a tour of the facility at			corrective actions are prepar	red
	10:12 a.m., the corridor door to resident room 29				and/or executed in complian	ce
		e frame when tested. Based on			with state and federal laws.	
		e of observation, the			This plan of correction	
		for agreed the corridor door			constitutes a written allegati	on
	would not latch into	the door frame.			of substantial compliance wi	th
					Federal Medicare and	
	This finding was reviewed with the Administrator, Maintenance Director and Regional Property				Medicaid requirements.	
	personnel at the exi				K363 – It is the intent of the	
	•				facility to ensure resident roon	n
	3.1-19(b)				corridor doors are provided wi	
					means suitable for keeping the	
					door closed, have no impedim	
					to closing, latching and will res	
					the passage of smoke to mee	
					standards.	
					1 CORRECTIVE ACTIONS	S
					TAKEN:	
					a On 9/27/2023 the	
					Maintenance Supervisor/design	gnee
					repaired the corridor door to	
					resident room 29 so the door	
					would close and latch fully into	the
					frame to meet set standards.	
					Administrator verified the work	con
					10/9/2023.	
					2 ALL OTHERS WITH	
					POTENTIAL TO BE AFFECTE	
					a All residents and all staff	
					and visitors have the potential	
					be affected but none were. The	•=
					Maintenance Supervisor/desig	gnee
					inspected all corridor doors to	
					ensure they close and latch fu	•
					into the frame and found no of	ther
					negative findings.	
					3 MEASURES TO PREVE	NT
					REOCCURRENCE:	
					l a On 9/27/2023 the	1

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>			COMPLETED	
		155223	B. WING 09/26/2023			2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	₹			LIBERTY ST			
WATERS OF COVINGTON, THE		THE		COVIN	GTON, IN 47932			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE	
					Administrator in-serviced the			
					Maintenance Supervisor/desig	jnee		
					and all staff on the requiremer	nt		
					that corridor doors must close			
					latch fully into the frame to me	et		
					set standards.			
					b Maintenance			
					Supervisor/designee will inspe			
					all corridor doors throughout the			
					facility monthly to ensure they			
					close and latch fully into the fr			
					as a part of the facility's Preve	ntive		
					Maintenance Program and			
					document those inspection res			
					as appropriate. If any issues			
					discovered, they will be addre			
					and resolved immediately. The			
					Maintenance Supervisor/design will review with the Administra			
					the inspection results.	lOI		
					c The Administrator will			
					monitor adherence to the			
					Preventative Maintenance			
					schedule and validate the			
					Preventative Maintenance			
					documentation is in place.			
					4 MONITORING			
					CORRECTIVE ACTION:			
					a The inspection results w	ill		
					be presented by the Maintena			
					Supervisor/designee to the			
					Administrator monthly and the			
					Administrator will present the			
					inspection results at the month	nly		
					Quality Assurance/Performan	ce		
					Improvement (QA/PI) meeting			
					Inspection results and system			
					components will be reviewed l	оу		
					the QA/PI Committee with			
					subsequent plans of correction	า		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2023			
		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932					
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
			developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/2023.				
Utilities - Gas and Equipment using gromplies with NFF Code, electrical with Code. Existing instance provided in 18.5.1.1, 19.5.1.1, Based on record revialled to ensure that a reliable source of requirements of NF 19.5.1.1, 9.1, 9.1.3. 5.1. LSC section 9. generators shall be maintained in accord Standard for Emerg Systems, 2010 Editifollowing energy soused for the emerge (1) Liquid petroleur pressure (2) Liquefied petroleur withdrawal) (3) Natural or synth Exception: For Level 2015 Exception: For Level 2016 Edition of the control of the con	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life. 9.1.1, 9.1.2 iew and interview, the facility the emergency generator had fuel in accordance with the PA 101 - 2012 edition, Section I and NFPA 110, 2010 Edition, 1.3.1 states emergency nstalled, tested and dance with NFPA 110, ency and Standby Power on. Section 5.1.1 states the urces shall be permitted to be ncy power supply (EPS): in products at atmospheric eum gas (liquid or vapor	K 0511	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wi Federal Medicare and Medicaid requirements.	t the set red ce			
	NFPA 101 Utilities - Gas and Equipment using g complies with NFF Code, electrical wi complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided n 18.5.1.1, 19.5.1.1, Based on record rev failed to ensure that a reliable source of requirements of NFI 19.5.1.1, 9.1, 9.1.3.1 5.1. LSC section 9. generators shall be i maintained in accord Standard for Emerge Systems, 2010 Editi following energy so used for the emerge (1) Liquid petroleum pressure (2) Liquefied petrole withdrawal) (3) Natural or synth Exception: For Leve where the probability	NFPA 101 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 Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor	NFPA 101 Utilities - Gas and Electric Code, electrical wiring and equipment complies with NFPA 54, National Electric 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 Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, S.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site	PROVIDER OR SUPPLIER SOF COVINGTON, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 4, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 5, 11, 9.1.1, 9.1.2, 1 and NFPA 110, 2010 Edition, Section 19.5.1.1, 9.1.3, 1 and NFPA 110, 2010 Edition, Section 19.5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency generators shall be permitted to be used for the emergency gower supply (EPS): (1) Liquified petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIE		1600 E	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST IGTON, IN 47932	
	SUMMARY (EACH DEFICIENT REGULATORY OF alternate energy so output of the EPSS specified shall be reproduced automatic transfer to the alternate energy so output of the EPSS specified shall be reproduced automatic transfer to the alternate energy so output of the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall be reproduced automatic transfer to the alternate energy specified shall	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION urce sufficient to allow full to be delivered for the class equired, with the provision for from the primary energy source rgy source. uples of probability of include the following: lamage, or a demonstrated . This deficient practice could	1600 E	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) facility to ensure the emergen generator has a reliable source fuel in accordance with the requirements of NFPA 101 – 2 edition, section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 edition, 5.1 to meet set standa 1 CORRECTIVE ACTION TAKEN: a On 9/27/2023 the Maintenance Supervisor/Administrator obta a letter from their natural gas provider indicating the natural is from a reliable source and documented the information in facilities Life Safety Binder to meet set standards. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all staf and visitors have the potentia be affected but none were. 3 MEASURES TO PREVE	cy be of 2012 ands. S sined agas on the ED: f
	Maintenance Direc	eviewed with the Administrator, itor and Regional Property it conference.		REOCCURRENCE: a On 9/27/2023 the Administrator in-serviced the Maintenance Supervisor/designon the requirement to have a from their natural gas provide file indicating the natural gas from a reliable source to meet standards. b The Maintenance Supervisor/designee will ensurate have a letter from their natural provider indicating the natural is from a reliable source on fil a part of the facility's monthly Preventive Maintenance	letter r on is t set lre to l gas gas

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/26/2023			
	ROVIDER OR SUPPLIER OF COVINGTON,		STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	THE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Program. If any issues are discovered, they will be address and resolved immediately. The Maintenance Supervisor/desig will review with the Administrate the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month 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	esed e nee oor		
K 0761 SS=E Bldg. 01				compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/2023.			

FORM CMS-2567(02-99) Previous Versions Obsolete

1. Based on observation, records review, and

Event ID:

XRFK21

K 0761

Facility ID: 000128

DISCLAIMER STATEMENT:

If continuation sheet

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09/27/2023

` ′		· /	IULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED B. WING 09/26/2023			
		155223	B. W	ING		09/26/2023	
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
			1600 E LIBERTY ST				
WATERS	OF COVINGTON,	THE		COVIN	GTON, IN 47932		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	COMPLETION		
TAG		LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE	
	· ·	ty failed to ensure annual			Preparation and/or execution	n	
	inspection and testing of 1 of 1 fire door				of this plan of correction in		
		xygen transfilling room door			general, or this corrective		
	-	accordance with LSC			action in particular, does not	t	
		unicating openings in dividing			constitute an admission or		
	_	d by 19.1.1.4.1 shall be			agreement by this facility of		
		orridors and shall be protected			facts alleged or conclusions	set	
		osing fire door assemblies. 3.) LSC 8.3.3.1 Openings			forth in this statement of		
	· ·			deficiencies. The plan of			
	required to have a fire protection rating by Table				correction and specific	rad	
	8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window				corrective actions are prepa		
	assemblies and their accompanying hardware,				and/or executed in complian with state and federal laws.	ce	
	including all frames, closing devices, anchorage,				This plan of correction		
	_	nce with the requirements of			constitutes a written allegati	on l	
		for Fire Doors and Other			of substantial compliance w		
		s, except as otherwise			Federal Medicare and	iui	
		de. NFPA 80 5.2.1 states fire			Medicaid requirements.		
	-	all be inspected and tested not			wedicald requirements.		
		and a written record of the			K761 – It is the intent of the		
		signed and kept for inspection			facility to ensure annual inspe	ction	
	-	80, 5.2.3.1 states functional			and testing of all fire door	Ollon	
	-	and window assemblies shall			assemblies are completed in		
	-	lividuals with knowledge and			accordance of LSC 19.1.1.4.1	1	
		e operating components of			and to ensure fire door assem		
	_	ng subject to testing. NFPA			are maintained in accordance		
		re door assemblies shall be			LSC 19.1.1.4.1.1 to meet set		
		rom both sides to assess the			standards.		
	overall condition of				1 CORRECTIVE ACTIONS	s	
		•			TAKEN:		
	NFPA 80, 5.2.4.2 st	tates as a minimum, the			a On 9/27/2023 the		
	following items sha	ll be verified:			Maintenance Supervisor/desig	gnee	
	(1) No open holes o	r breaks exist in surfaces of			conducted the annual inspecti	ion	
	either the door or fr	ame.			of the oxygen transfilling room		
	(2) Glazing, vision	light frames, and glazing beads			door assembly and document		
	are intact and secure	ely fastened in place, if so			the inspection results on the		
	equipped.				Annual Door Inspections log to	0	
	(3) The door, frame	, hinges, hardware, and			meet set standards. The		
	noncombustible thro	eshold are secured, aligned,			Administrator verified the		
	and in working order with no visible signs of				inspection and documentation	on	

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155223	B. WING		09/26/2023	
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF COVINGTON,	THE	COVIN	IGTON, IN 47932		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	damage.			10/9/2023.		
	(4) No parts are mis	ssing or broken.		b On 9/27/2023 the		
	-	s do not exceed clearances		Maintenance Supervisor/desig	nee	
	listed in 4.8.4 and 6			removed the paint from the fire	•	
	(6) The self-closing	device is operational; that is,		resistance rating labels affixed	•	
		apletely closes when operated		both doors in the corridor door	•	
	from the fully open			by the beauty shop to meet se		
		is installed, the inactive leaf		standards. The Administrator		
	closes before the ac			verified the work on 10/9/2023		
	(8) Latching hardware operates and secures the			Vermed the Work on 10/3/2020	,, 	
	door when it is in the closed position.			2 ALL OTHERS WITH		
	(9) Auxiliary hardware items that interfere or			POTENTIAL TO BE AFFECTE	-n·	
	prohibit operation are not installed on the door or			a All residents and all staff		
	frame.	are not instance on the door of		and visitors have the potential		
		fications to the door assembly		be affected but none were.	10	
	, ,	ed that void the label.		3 MEASURES TO PREVE	NT	
	_	edge seals, where required, are		REOCCURRENCE:		
		their presence and integrity.		a On 9/27/2023 the		
		ice could affect at least 10		Administrator/corporate Prope	arty.	
	residents and staff.	nee could affect at least 10		Manager inserviced the	ity	
	residents and starr.			Maintenance Supervisor/desig	1000	
	Findings include:			on the requirement that annua	•	
	Findings include.			testing & inspections of fire do		
	Rased on record res	view with the Maintenance		assemblies, including the door		
		23 from 11:48 a.m. to 1:52 p.m		the oxygen transfilling room, n	•	
		n of the oxygen transfilling		be conducted, and documente		
	-	y was available for review.				
		on during the tour between		the Annual Door Inspections lo	=	
		45 a.m., there was an oxygen		and fire resistance rating label affixed to doors must be	io	
		ear the activity room with a one				
		rated door. Based on interview		maintained and not painted to		
				meet set standards.		
		ds review, the Maintenance he was unaware that the		b Maintenance	ro to	
				Supervisor/designee will ensu		
		room fire door needed to be		conduct the annual inspection		
	inspected annually.			fire door assemblies, including	tne	
	TEL: (* 1:			door to the oxygen transfilling		
		viewed with the Administrator,		room and document those		
		tor, and Regional Property		inspection results as appropria	•	
	personnel at the exit conference.			and will ensure to maintain fire	e	

resistance labels affixed to doors

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155223	B. W	ING		09/26/	2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8			LIBERTY ST			
WATERS	OF COVINGTON,	THE		COVINGTON, IN 47932				
	ı				, -	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		ation and interview; the facility			and ensure there is no paint o			
		f 10 fire door assemblies were			any other material obstructing			
		dance with LSC 19.1.1.4.1.1.			fire resistance labels to meet	set		
		enings in dividing fire barriers			standards. If any issues are	_		
	required by 19.1.1.4.1 shall be permitted only in				discovered, they will be addre			
		be protected by approved			and resolved immediately. Th			
	_	or assemblies. (See also Section			Maintenance Supervisor/desig			
	1	penings required to have a fire			will review with the Administra	itor		
		Table 8.3.4.2 shall be			the inspection results.			
		ved, listed, labeled fire door			c The Administrator will			
	assemblies and fire window assemblies and their				monitor adherence to the			
		ware, including all frames,			Preventative Maintenance			
	closing devices, anchorage, and sills in				schedule and validate the			
		e requirements of NFPA 80,			Preventative Maintenance			
		oors and Other Opening			documentation is in place.			
	_	as otherwise specified in this			4 MONITORING			
	Code. NFPA 80 5.2	.1 states fire door assemblies			CORRECTIVE ACTION:			
	shall be inspected a	nd tested not less than			a The inspection results w	ill		
	annually, and a writ	tten record of the inspection			be presented by the Maintena	nce		
	shall be signed and	kept for inspection by the			Supervisor/designee to the			
	AHJ. NFPA 80, 5.2	.4.1 states fire door assemblies			Administrator monthly and the	;		
	shall be visually ins	spected from both sides to			Administrator will present the			
	assess the overall co	ondition of door assembly.			inspection results at the month	nly		
					Quality Assurance/Performan	ce		
		tates as a minimum, the			Improvement (QA/PI) meeting	J.		
	following items sha	ll be verified:			Inspection results and system			
	(1) No open holes o	or breaks exist in surfaces of			components will be reviewed I	by		
	either the door or fr	ame.			the QA/PI Committee with			
	(2) Glazing, vision	light frames, and glazing beads			subsequent plans of correction	n		
	are intact and secur	ely fastened in place, if so			developed and implemented a	as		
	equipped.				deemed necessary to ensure			
		, hinges, hardware, and			compliance is maintained.			
	noncombustible thr	eshold are secured, aligned,			This plan of correction			
	and in working orde	er with no visible signs of			constitutes our credible			
	damage.	-			allegation of compliance with	h		
	(4) No parts are mis	ssing or broken.			all regulatory requirements.			
		do not exceed clearances			Our date of compliance is			
	listed in 4.8.4 and 6				9/27/2023.			
		device is operational; that is,						
		the active door completely closes when operated						

f ´		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155223					LETED /2023
		100220	B. WI			09/26	12023
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WATER!	S OF COVINGTON,	THE		1600 E LIBERTY ST COVINGTON, IN 47932			
	T				1		1
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	from the full open p						
	(7) If a coordinator	is installed, the inactive leaf					
	closes before the ac						
		are operates and secures the					
	door when it is in th	-					
		vare items that interfere or					
		re not installed on the door or					
		frame. (10) No field modifications to the door assembly					
	have been performe						
	(11) Gasketing and						
	inspected to verify t						
	This deficient practice could affect over 15						
	residents, staff and visitors.						
	Findings include:						
	i manigs merade.						
	Based on observation	on with the Maintenance					
	Director during a to	our of the facility at 10:17 a.m.					
		e resistance rating labels affixed					
		corridor door set by the					
		ainted. Based on interview at					
		rvation, the Maintenance					
		the fire resistance rating labels					
	on the doors were p	amucu.					
	This finding was re	viewed with the Administrator,					
	_	or and Regional Property					
	personnel during the	e exit conference.					
	3.1-19(b)						
K 0911	NFPA 101						
SS=E	Electrical Systems						
Bldg. 01	Electrical Systems						
		RKS section any NFPA 99					
		al Systems requirements					
		ssed by the provided					
	_	eficient. This information, blicable Life Safetv Code or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XRFK21 Facility ID: 000128

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
	155223		B. WING 09/26/2023			2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	ADDOLUBERG N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
PREFIX	REGULATORY OR NFPA standard cit on Form CMS-256 Chapter 6 (NFPA Based on observation failed to ensure accommaintained in encloin the entry/lounge and section 6.3.2.1 states in accordance with Code. NFPA 70, 20 states access and work provided and maintate equipment to permit maintenance of such for equipment operaless and likely to respect to the servicing, or maintenance of such for equipment operaless and likely to respect to the servicing, or maintenance of such for equipment operaless and likely to respect to the servicing of the servicing of the servicing space in the not be less than that (1) which the minimulation of the width of the equipment of the width of the equipment doors or states the workspace from the grade, floof 61?2 feet or the height whichever is greater whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the height whichever is greater than the service of the service of the height whichever is greater than the service of the serv	cy Must be preceded by full attion, should be included by the facility can and interview, the facility can and working space was sures housing electrical panels area mechanical room. NFPA calities Code, 2012 Edition, can be electrical installation shall be nFPA 70, National Electric coll Edition, Article 110.26 corking space shall be canned about all electrical at ready and safe operation and the equipment. Working space cating at 600 volts, nominal, or equire examination, adjustment, cannec while energized shall mensions of 110.26(A) (1), (2) (1) states the depth of the electrical can distance is 3 feet. So the width of the working electrical equipment shall be appendix or 762 mm (30 in.), and in all cases, the workspace as 90-degree opening of hinged panels. 110.26(A)(3) the shall be clear and extend for, or platform to a height of the equipment, and the fact of the equipment of the equipment, and the fact of the equipment of the equipment of the equipment, and the fact of the equipment of	K 0	PREFIX	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of corrective action and specific corrective actions are preparation of substantial compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with substantial compliance wi	the set red ce on ith	COMPLETION
	working space required by this section shall not			removed the items stored in front		ont	
	be used for storage. This deficient practice could affect staff in the vicinity of the entry/lounge area.			of the electrical panels in the			
	affect staff in the vicinity of the entry/lounge area.				mechanical room to meet set		
	Findings include: Based on observations during a tour of the facility				standards. The Administrator verified the removal of the iter		
					10/9/2023.	IIO UII	
					2 ALL OTHERS WITH		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XRFK21 Facility ID: 000128

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155223		B. WING 0			09/26	09/26/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LIBERTY ST		
WATERS OF COVINGTON, THE			COVINGTON, IN 47932				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		ice Director on 09/26/23 at			POTENTAL TO BE AFFECTED:		
		chanical room by the employee		a All residents and all staff		f	
	time clock had three electrical panels, generator			and visitors have the potential to		to	
	transfer switch that were blocked from access with			be affected but none were. On		n	
	four flatscreen televisions and other items stored			9/27/2023 the Maintena			
	_	ls. Based on interview at the		Supervisor/designee inspe			
		tion, the Maintenance Director		other areas and found no other		er .	
	_	stored within the working space		negative findings.			
	in front of the elect	rical panels.		3 MEASURES TO PREV		:NT	
					REOCCURRENCE:		
	The finding was reviewed with the Administrator,				a On 10/10/2023 the		
		tor and Regional Property			Administrator in-serviced the		
	personnel during th	e exit conference.			Maintenance Supervisor/desig	jnee	
					and all other staff on the		
	3.1-19(b)				requirement that nothing is to		
					impede access to workspaces		
					including electrical power pan	els	
					to meet set standards.		
					b Maintenance		
					Supervisor/designee will inspe	ect	
					all electrical power panels		
					throughout the facility weekly		
					ensure there are no impedime		
					to accessing the panels as a	oart	
					of the facility's Preventive		
					Maintenance Program and		
					document those inspection re		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. The		
					Maintenance Supervisor/desig	-	
					will review with the Administra	itor	
					the inspection results.		
					c The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
			1		i /i Michilichelbica		1

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

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) CORRECTIVE ACTION: a The inspection results we be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is	ill nce nlly ce l. by	(X5) COMPLETION DATE
					10/10/2023.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XRFK21 Facility ID: 000128 If continuation sheet Page 41 of 41