STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BUILDING COMPL B. WING 03/07/		(X3) DATE SURVEY COMPLETED 03/07/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
WATERS (X4) ID PREFIX TAG E 0000 Bldg	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 0000			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) March 24, 2023 Brenda Buroker, Director Long term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: YYZR2 Please accept the following p correction as credible evidence compliance to the deficiencies cited during our recent Annual Safety Code Recertification S	I lan of ce of sil Life urvey		
	Quality Review con	at the time of this survey. mpleted on 03/14/23 VIDER/SUPPLIER REPRESENTATIVE'S SI		on March 7, 2023 at The Wat of Tipton SNF. Hopefully, you find that our remedies are bot sufficient and thoroughly expl in providing you a clear pictur how we corrected these concerns. With this submission of these remedies, we are requesting paper compliance. If after reviewing our plan of correctic you have any questions, or refurther information, please do hesitate to contact me at your convenience at 765-675-8791 Respectfully submitted, Paula Juday, HFA, LMSW Administrator The Waters of Tipton	u will h ained e of on, equire not		

Paula Juday Administrator 03/24/2023

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155556	B. WI	NG		03/07	/2023
	PROVIDER OR SUPPLIEI S OF TIPTON SKIL	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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)	TE	DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey v Department of Hea 483.90(a). Survey Date: 03/0' Facility Number: 0 Provider Number: 100/2 At this Life Safety Tipton Skilled Nur- compliance with Re Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This two story facil Type V (111) const sprinklered. The fa with smoke detection to the corridors and detectors in the resi capacity of 150 and of this survey. All areas where the access were sprinkl facility services we	Recertification and State was conducted by the Indiana lth in accordance with 42 CFR 7/2023 000505 155556 266350 Code survey, The Waters of sing Facility was found not in equirements for Participation in I, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. It was determined to be of truction and was fully acility has a fire alarm system on in the corridors, areas open I battery operated smoke ident rooms. The facility has a I had a census of 98 at the time	K 00		March 24, 2023 Brenda Buroker, Director Long term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: YYZR21 Please accept the following pl correction as credible evidence cited during our recent Annual Safety Code Recertification St on March 7, 2023 at The Wate of Tipton SNF. Hopefully, you find that our remedies are bott sufficient and thoroughly explain in providing you a clear picture how we corrected these concerns. With this submission of these remedies, we are requesting paper compliance. If after reviewing our plan of correction you have any questions, or refurther information, please do hesitate to contact me at your convenience at 765-675-8791 Respectfully submitted,	an of the of	
	Zumity Keview col	inpleted on 05/1 1/25			Paula Juday HFA I MSW		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	LIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 03/07/2023	
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IIRGROUNDS RD N, IN 46072		
(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	
				Administrator The Waters of Tipton		
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 2 of were continuously robstructions. This considents. Findings include: Based on an observation facility with the Ma 03/07/23 at 3:25 p.r. again by room 22, titable against the way about two feet. Based of observations, the workspace in the contraction of	A General ays, corridors, exit cations, and accesses are in Chapter 7, and the means accessed in Chapter 18,19.2.2 and and interview, the facility of 2 corridor means of egresses an intained free of deficient practice affects 20 action during a tour of the intenance Assistant (MA) on in., in the corridor by room 8 and there was a chair and overbed all protruding into the corridor ed on an interview at the time intenance MA agreed it was a stridor.	K 0211	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does no 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 compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance we rederal Medicare and Medicaid requirements. K211 – It is the intent of the facility to ensure corridor mean egresses are continuously maintained free of all obstruct to meet set standards.	t the set red ace on ith	

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	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/07/2023
	ROVIDER OR SUPPLIE OF TIPTON SKIL	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP CO IIRGROUNDS RD N, IN 46072	D
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ection (X5) ULLD BE COMPLETION DATE
				1. CORRECTIVE ACTAKEN: a. On 3/8/2023 the Maintenance Supervisor removed the chair and contable from the corridor by and by room 22 to meet standards. The Administration of the work on 3/8/2. ALL OTHERS WIPOTENTIAL TO BE AFF a. All residents and and visitors have the population of	r/designee overbed by room 8 set trator '2023. TH FECTED: all staff tential to ere. On noce spected all s and findings. PREVENT I the r/designee staff on e corridor remain neet set I inspect ress eekly for f the ntenance those propriate. ered, they esolved ienance

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MUI A. BUI B. WIN	LDING	nstruction <u>01</u>	(X3) DATE S COMPL 03/07/	ETED
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE		300 FAI	NDDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
					with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results to be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan 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 3/24/2023.	hly ce J. by	
K 0222 SS=E Bldg. 01	be equipped with a requires the use o	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	ľ í	UILDING	nstruction 01	(X3) DATE COMPL 03/07/	ETED
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		300 FAI	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(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 DEFICIENCY)	.TE	(X5) COMPLETION
TAG	CLINICAL NEEDS	S OR SECURITY THREAT		TAG	DEFICIENCY		DATE
	LOCKING Where special loc	king arrangements for the					
	1	eeds of the patient are cking device shall be					
	permitted on each	door and provisions shall					
		apid removal of occupants I of locks; keying of all					
	1 -	ied by staff at all times; or					
		e means available to the					
	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6						
	SPECIAL NEEDS LOCKING ARRANGEMENTS						
	· ·	king arrangements for the					
	· ·	e patient are used, all of curity Locking requirements					
		addition, the locks must be					
		at fail safely so as to					
	1	of power to the device; the					
		ed by a supervised er system and the locked					
	1	d by a complete smoke					
		(or is constantly monitored					
	1	cation within the locked					
	space); and both	the sprinkler and detection					
	systems are arrar	nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2						
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking in accordance with					
	1 -	permitted on door					
		ig low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle	er system.					

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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>		01	COMPLETED	
		155556	B. WI	NG		03/07/2023	
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2. Based on observation failed to ensure the 1 exit doors at the N accessible for resided diagnosis requiring Doors within a requise equipped with a use of a tool or key otherwise permitted Door-locking arrang accordance with 19 practice could affect entrance area. Findings include: Based on observation Assistant (MA) on door at the Main en exit, was magnetical opened by entering access control pad,	NGLLED EGRESS NGEMENTS I Egress Door assemblies I ance with 7.2.1.6.2 shall I EXAMPLE AND	K 02	222	K222— It is the intent of the facto ensure the means of egress through exit doors at the main entrance is readily accessible residents without a clinical diagnosis requiring specialize security measures to meet sestandards. 1. CORRECTIVE ACTION TAKEN: a. On 3/8/2023 the Maintenance Supervisor/designosted information on how to obtain the code at the exit doo the Main Entrance to meet sestandards. The Administrator verified the work on 3/8/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTIAL T	for d t S gnee or at t	03/24/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/07/2023
	PROVIDER OR SUPPLIEF	LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
	observation, the Ma exit door was not pe pad and stated there resident leaving the	A agreed the code to open the osted by the access control was a concern with a facility.		Supervisor/designee inspect doors to ensure information how to obtain the codes was present and found no other negative findings. 3. MEASURES TO PRE REOCCURRENCE: a. On 3/8/8023 the Administrator inserviced the Maintenance Supervisor/designed and on 3/24/2023 all other sthe requirement that information obtain the codes must be postated at the exit doors to meet set standards. b. Maintenance Supervisor/designee will insulate all means of corridor doors to ensure they have information obtain the codes as a of the facility's Preventive Maintenance Program and document those inspection is a appropriate. If any issued discovered, they will be add and resolved immediately.	ted all on s VENT signee taff on ation to osted pect weekly tion on a part results es are ressed
				Maintenance Supervisor/des will review with the Administ 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 be presented by the Mainten Supervisor/designee to the	signee rator

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155556	A. BU B. WI		01	COMPLETED 03/07/2023	
		100000	D. W1			03/07/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD		
WATERS	OF TIPTON SKILL	ED NURSING FACILITY, THE	_		I, IN 46072		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records refailed to ensure 9 of lights were tested at 7.9.3.1.1 (1) require conducted monthly, and a maximum of eless than 30 seconds be conducted annual hours if the emerger powered and (5) Whinspections and tests for inspection by the	g of at least 1-1/2-hour and automatically in 1.9. view and interview, the facility of 9 battery backup emergency annually for 90 minutes. Section as functional testing shall be with a minimum of 3 weeks of weeks between tests, for not so, (3) Functional testing shall lly for a minimum of 1 1/2 may lighting system is battery written records of visual so shall be kept by the owner as authority having efficient practice could affect all	K 02	291	Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand 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 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 3/24/2023. K291 – It is the intent of the facility to ensure battery backuemergency lights are tested annually for 90 minutes to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 3/24/2023 the Maintenance Supervisor/design conducted the annual testing of the battery backup emergency lights that was past due and documented the results on the Battery-Operated Emergency	inly ce by in sis in the state of the	03/24/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/07/2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD N, IN 46072	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION DATE
		eview with the Maintenance 03/07/23 at 11:55 a.m., annual		Lights and signs Test Log set standards. The Admir verified the work on 3/24/2 2.ALL OTHERS WITH POTENTIAL TO BE AFFE	nistrator 2023.
	was past due. Base of records review, t	ry backup emergency lights d on an interview at the time he MA stated the annual 90 he nine battery backup		1.All residents and all and visitors have the pote be affected but none were 3.MEASURES TO PREV	ntial to
		as not been conducted in the		REOCCURRENCE: 1.On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/of	ne
				on the requirement to prov maintain emergency lightic conduct the monthly and a testing and document the	vide and ng and annual
				to meet set standards. 2.Maintenance Supervisor/designee will e provide and maintain eme	ensure to
				lighting and conduct the m and annual testing as a pa facility's Preventive Mainte	nonthly art of the enance
				Program and document the tests on the Battery-Opera Emergency Lights and sig Log and will maintain eme	ated ns Test
				lighting to meet set standa any issues are discovered will be addressed and resimmediately. The Mainter	l, they olved
				Supervisor/designee will r with the Administrator the inspection results. 3.The Administrator v	eview
				monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/07/2023
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP CO NRGROUNDS RD N, IN 46072	OD .
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE COMPLETION DATE
				documentation is in place 4.MONITORING COR ACTION: 1.The inspection reduced by the Massupervisor/designee to Administrator monthly and Administrator will prese inspection results at the Quality Assurance/Performerovement (QA/PI) or Inspection results and so components will be revited the QA/PI Committee was ubsequent plans of condeveloped and implement deemed necessary to ecompliance is maintained. This plan of correction constitutes our credibulance all regulatory requirem Our date of compliance 3/24/2023.	esults will esults will eintenance the and the ent the emonthly formance fleeting. eystem fleewed by fith frection fleetineted as fleetineted
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinuction accordance with 8 approved automation option is used, the from other spaces partitions and dood Doors shall be sel automatic-closing	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET				
		155556	B. WIN	IG		03/07	/2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•	
					IRGROUNDS RD		
WATERS	WATERS OF TIPTON SKILLED NURSING FACILITY, THE			TIPTON	N, IN 46072		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	do not exceed 48 inches from the bottom of the door.						
		r and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler						
	Separation	N/A					
	'	I-Fired Heater Rooms					
		ger than 100 square feet)					
	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)						
	e. Trash Collection	on Rooms					
	(exceeding 64 ga	llons)					
		orage Rooms/Spaces					
	(over 50 square f	eet)					
	g. Laboratories (it	f classified as Severe					
	Hazard - see K32	•					
		on and interview, the facility	K 03	21	K321– It is the intent of the facility		03/24/2023
		of 1 storage rooms on the 2nd			to ensure storage rooms on the		
	_	rith large amounts of			2nd floor dining area with larg		
	_	e and greater than 50 square			amounts of combustible stora	-	
	_	as a hazardous area. This			and greater than 50 square fe		
	_	could affect 30 residents in the			protected as a hazardous are	a to	
	2nd floor dining ar	ea.			meet set standards.		
	Eindings in slude.				1. CORRECTIVE ACTION	ıs	
	Findings include:				TAKEN: a. On 3/24/2023 the		
	Based on observati	on during a tour of the facility			a. On 3/24/2023 the Maintenance Supervisor/desi	anee	
		Assistant on 03/07/23 at 2:50			removed the boxes of supplie	-	
		dining area storage room			from the 2nd floor dining area		
	_	boxes of supplies and was			storage room to meet set		
		are feet making this a			standards. The Administrator		
	hazardous area. The storage room was not				verified the work on 3/24/2023	3.	
		rdous area because there was			2. ALL OTHERS WITH	-	
	_	Based on interview at the time of			POTENTIAL TO BE AFFECT	ED:	
		aintenance Assistant agreed			a. All residents and all sta		
		ontained a large amount of			and visitors have the potentia		

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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 01 COMPLETED				
		155556	B. WI	NG		03/07/	/2023
NAME OF I	PROVIDER OR SUPPLIER	<u>. </u>	1		ADDRESS, CITY, STATE, ZIP COD	-	
WATERS	S OF TIPTON SKII I	LED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072				
(X4) ID	T	STATEMENT OF DEFICIENCIE	1	ID ID	<u> </u>		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		e, was larger than 50 square			be affected but none were. O	n	
	feet, and there was				3/24/2023 the Maintenance		
					Supervisor/designee inspecte	d all	
	The finding was rev	viewed with the Administrator			hazardous areas for combusti	ble	
	and the Maintenanc	e Assistant during the exit			storage and found no other		
	conference.				negative findings.		
					3. MEASURES TO PREVE	ENT	
	3.1-19(b)				REOCCURRENCE:		
					a. On 3/8/2023 the		
					Administrator inserviced the		
					Maintenance Supervisor/desig	gnee/	
					and 3/24/2023 all staff on the		
					requirement that all hazardous		
					areas must be protected with	а	
					corridor door to meet set		
					standards. b. Maintenance		
					Supervisor/designee will inspe	act	
					all hazardous areas throughou		
					facility to ensure there is a cor		
					door as a part of the facility's	iidoi	
					Preventive Maintenance Prog	ram	
					and document those inspection		
					results as appropriate. If any		
					issues are discovered, they w		
					addressed and resolved		
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					with the Administrator the		
					inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING CORRECTIVE ACTION:		
						vill	
					a. The inspection results v		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BUILDING B. WING	01	COMPLETED 03/07/2023	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cooking * residential cooking appliances such as toasters) are used cooking in accordant 19.3.2.5.2 * cooking facilities smoke compartments comply wing the same accordant 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1	FPA 96, Standard for and Fire Protection of ng Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in nts with 30 or fewer th the conditions under 5.3, or in smoke compartments		Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand 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 3/24/2023.	nly ce by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155556	B. WING 03/07/2023			2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			IRGROUNDS RD		
\MATERS	S OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON, IN 46072			
With the string terror of the			111 101	1, 114 4007 2	,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF T		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	NFPA 96 per 9.2.3 are not required to be						
		rdous areas, but shall not					
	be open to the co						
		n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
		on and interview, the facility	K 0	324	K324- It is the intent of the fa	cility	03/08/2023
		ff had access to the shutoff			to ensure staff has access to	the	
		ectric range in the back Dining			shutoff switch for the electric		
		5.4 states within a smoke			range in the back Dining Rooi	m to	
	_	ential or commercial cooking			meet set standards.		
	equipment that is u	sed to prepare meals for 30 or			1. CORRECTIVE ACTIONS		
	fewer persons shall be permitted, provided that				TAKEN:		
	the cooking facility complies with all of the				a. On 3/8/2023 the		
	following condition	ns:			Administrator/designee inserv	riced	
	(1) The space conta	ining the cooking equipment			the Activities Department		
	is not a sleeping ro	om.			Staff/designee on the requirer	ment	
	(2) The space conta	nining the cooking equipment			to deactivate the power to the	!	
	shall be separated f	rom the corridor by partitions			electric range in the back Dini	ng	
	complying with 19	3.6.2 through 19.3.6.5.			Room when the kitchen is not		
	(3) The requiremen	ts of 19.3.2.5.3(1) through (10)			under staff supervision and to)	
	and (13) are met.				ensure the cabinet is locked to	0	
	19.3.2.5.3(9) states	A switch meeting all of the			meet set standards. The cabir	net	
	following is provid	ed:			was locked on 3/8/2023. The		
	(a) A locked switch	n, or a switch located in a			Administrator verified the worl	k on	
	restricted location,	is provided within the cooking			3/8/2023 .		
	facility that deactiv	ates the cooktop or range.			2. ALL OTHERS WITH		
		sed to deactivate the cooktop			POTENTIAL TO BE AFFECT	ED:	
	or range whenever	the kitchen is not under staff			a. All residents and all staff a	nd	
	supervision.				visitors have the potential to b	e	
	This deficient pract	ice could affect one resident in			affected but none were.		
	the back Dining roo	om.			3. MEASURES TO PREVENT	•	
					REOCCURRENCE:		
	Findings include:				a. Maintenance		
					Supervisor/Activity Staff/desig	jnee	
	Based on observation	on with the Maintenance			will ensure they have access	to	
	Assistant (MA) on	03/07/23 at 3:55 p.m., there was			the shutoff switch for electric		
	an electric range in	the back Dining room that was			ranges as appropriate and en	sure	
	separated from the	corridor, but staff did not			it is shut down when not unde		
	_	e from power when the kitchen			staff supervision and ensure t	he	
		supervision. Based on			cabinet is locked at all times v		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		A. BUILDING <u>01</u> COMI		(X3) DATE SURVEY COMPLETED 03/07/2023	
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 F	FADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD DN, IN 46072	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	asked if staff were a and lock the switch switch is in a locked deactivate the power The finding was revand MA during the 3.1-19(b)	e of observation, the MA was ble to deactivate the cooktop The MA agreed the shut off deabinet but staff neglected to refere they left the area. iewed with the Administrator exit conference.		not in use. If any issues are discovered, they will be addre and resolved immediately. The Maintenance Supervisor/desi will review with the Administrative inspection results. b. The Administrator will more adherence to the Policies and Procedures regarding the use the range in the back dining rarea. 4. MONITORING CORRECTI ACTION: a. The monitoring results will presented by the Administrative the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Inspection 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 allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.	the gnee ator nitor d e of coom VE be be cor at g. n by on as
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing	Maintenance and Testing Maintenance and Testing or and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPI	
			155556	B. W	ING		03/07	/2023
		ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		300 FA	REET ADDRESS, CITY, STATE, ZIP COD 00 FAIRGROUNDS RD PTON, IN 46072		
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO		ATE	COMPLETION
	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	TAG	Records of system inspection and test secure location are a) Date sprinkler. b) Who provided c) Water system. Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8. Based on record revialled to maintain 1 accordance with 19 14.2.1 states except 14.2.1.4 an inspectic conditions shall be opening a flushing of main and by remove of one branch line if for the presence of material. This defic occupants. Findings include: Based on record revial Assistant (MA) on the internal inspection on the found. Based on record review, the Maccompleted in the last completed in the last complete completed in the last complete completed in the last complete complete completed in the last complete co	n design, maintenance, sting are maintained in a and readily available. system last checked system last checked system test supply source RKS information on non-required or partial er system. and NFPA 25 view and interview, the facility of 1 sprinkler system in 3.5.3. NFPA 25, 2011 Edition, as discussed in 14.2.1.1 and on of piping and branch line conducted every 5 years by connection at the end of one ing a sprinkler toward the end for the purpose of inspecting foreign organic and inorganic ient practice could affect all riew with the Maintenance 03/07/23 at 1:55 p.m., the of piping documentation was an interview at the time of MA agreed there was no in internal pipe inspection at 5 years.	K 0		K353 – It is the intent of the facility to ensure to maintain it sprinkler system in accordance with 19.3.5.3 to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 3/8/2023 the Maintenance Supervisor/designeceived the documentation of their last 5 year internal pipe inspection and documented thresults to meet set standards. The Administrator verified the on 3/8/2023. 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTION 1.All residents and all stand visitors have the potential be affected but none were. 3.MEASURES TO PREVENTING REOCCURRENCE: 1.On 3/8/2023 the Administrator inserviced the	gnee f ne work ED: aff I to	03/08/2023
		3.1-19(b)				Maintenance Supervisor/desig	JI ICC	
		」 ン.1-17(ひ)		1		i on the requirement that the		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/07/2023	
	ROVIDER OR SUPPLIE OF TIPTON SKIL	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD NIRGROUNDS RD N, IN 46072	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				sprinkler system must have a internal pipe inspection every years and results documented the facility to meet set standard. 2. Maintenance Supervisor/designee will ensithe 5 year internal pipe inspection for the sprinkler system is conducted as a part of the facility's Preventive Maintenar Program and document those inspection results as approping any issues are discovered, will be addressed and resolv immediately. The Maintenar Supervisor/designee will review the Administrator the inspection results. 3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECT ACTION: 1. The inspection results be presented by the Maintenance documentation will present the inspection results at the more Quality Assurance/Performa Improvement (QA/PI) meetir Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure	an y 5 ed at ards. Sure ection ance se riate. In they red se iew TIVE Swill sance se enthly sance se enthly sonce se end

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 03/07/2023					
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
				compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/8/2023.			
K 0355 SS=D Bldg. 01 Portable Fire Extinguishers Portable fire extinguishers Portable fire extinguishers are sel installed, inspected, and maintain accordance with NFPA 10, Stand- Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, failed to ensure 1 of 1 portable fire extinguishers accordance with NFPA 10, Standard Fire Extinguishers, 2010 Edition. See states portable fire extinguishers othe wheeled extinguishers shall be instal of the following means. (1) Securely		nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of 1 portable fire extinguishers in op were installed in FPA 10, Standard for Portable 2010 Edition. Section 6.1.3.4 extinguishers other than ers shall be installed using any eans. (1) Securely on a hanger inguishers. (2) In the bracket	K 0355	K355– It is the intent of the faci to ensure portable fire extinguishers are installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition to meet set standards. 1.CORRECTIVE ACTIONS TAKEN:			
	listed bracket approcabinet or wall rececould affect staff in Findings include: Based on observation with the Maintenand 4:15 p.m., a portable maintenance shop was cured. Based of	nguisher manufacture. (3) In a eved for such purpose. (3) In a ss. This deficient practice the maintenance shop. ons during a tour of the facility ce Assistant on 03/07/23 at e fire extinguisher in the evas sitting on the floor on interview at the time of the facility continues the time of the formal continues and the floor on interview at the time of the formal continues and the floor on interview at the time of the formal continues and the floor on interview at the time of the formal continues and the floor on interview at the time of the floor on interview at the time of the floor on the floor on interview at the time of the floor on the floor		a. On 3/8/2023 the facilities Maintenance Supervisor/design secured the portable fire extinguisher in the maintenance shop to meet set standards. The Administrator verified the work 3/8/2023. 1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED 1.All residents and all staff and visitors have the potential the affected but none were. 2.MEASURES TO PREVENT	nee e ne on D: f		
	extinguisher was si	e e		REOCCURRENCE:			

1.On 3/8/2023 the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155556		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/07/2023			
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	_	viewed with the Administrator sistant at the exit conference.		Administrator inserviced the Maintenance Supervisor/design that portable fire extinguishers must be installed in accordance with NFPA 10 to meet set standards. 2.Maintenance Supervisor/designee will ensured.	ce Ire		
				portable fire extinguishers are readily accessible and installe accordance with NFPA 10 as part of the facility's Monthly Preventive Maintenance Prog and document those inspection results as appropriate. If any	ed in a ram on		
				issues are discovered, they wanddressed and resolved immediately. The Maintenand Supervisor/designee will reviewith the Administrator the	ill be ce		
				inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance			
				documentation is in place. 3.MONITORING CORRECT ACTION: 1.The inspection results	will		
				be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont	•		
				Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with	ce J.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/07/2023	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD N, IN 46072	
(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
V 0364	NEDA 404			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 wit all regulatory requirements. Our date of compliance is 3/8/2023.	as
K 0361 SS=E Bldg. 01	treatment rooms a waiting areas, nur and cooking facilit				
	failed to ensure 1 of of combustible stora not used as hazardo states that spaces of rooms, treatment ro be open to the corri- provided: (a) The sp space opens onto in are protected by an automatic smoke de with 19.3.4, and (b) automatic sprinklers to obstruct access to	ation and interview, the facility of 1 rooms with a large quantity age open to the corridor was us storage. LSC 19.3.6.1(7) ther than patient sleeping oms, and hazardous areas shall dor and unlimited in area, bace and corridors which the the same smoke compartment electrically supervised stection system in accordance Each space is protected by an standard of the corresponding to the product of the space does not be required exits. This deficient to 15 residents in the Activity	K 0361	K361 – It is the intent of the facility to ensure rooms with a large quantity of combustible storage open to the corridor is used as hazardous storage an ensure nursing station with a pass-through window greater 20 square inches meet the requirements of spaces open the corridor to meet set stand. 1. CORRECTIVE ACTION TAKEN: a. On 3/24/2023 the Maintenance Supervisor/designed removed the combustible materials from the Activity officiarea including the boxes of supplies, plastic containers ar	s not and to than to ards.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG	01	COMPL	ETED
		155556	B. WING			03/07/	/2023
			STI	REET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIER	₹			RGROUNDS RD		
WATER	S OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON, IN 46072			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	ΊΧ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
	Based on observation	on with the Maintenance			activity items to meet set		
	Assistant (MA) on	03/07/23 at 4:00 p.m., the			standards.		
	Activity office area	was open to the corridor and			b. On 3/8/2023 the		
	was being used to s	tore combustible material such			Maintenance Supervisor/desig	nee	
	as boxes of supplies	s, plastic containers, and			installed plexiglass to the 2nd	floor	
	activity items. This	condition does not protect the			nursing station window, that is		
		ardous storage area. Based on			longer used as a nurse's station		
	interview at the tim	e of observation, MA agreed			that had an opening at the ceil		
		was open to the corridor and it			to meet set standards.	Ü	
		tore Activity supplies.			2. ALL OTHERS WITH		
		• ••			POTENTIAL TO BE AFFECTE	D:	
	2. Based on observation and interview, the facility				a. All residents and all staf		
		f 1 nursing station with a			and visitors have the potential	to	
		ow greater than 20 square			be affected but none were.		
		irements of spaces open to the			3. MEASURES TO PREVE	NT	
	_	6.1(7) states that spaces other			REOCCURRENCE:		
		g rooms, treatment rooms, and			a. The administrator inserv	/iced	
	_	all be open to the corridor and			the maintenance supervisor or	า	
		rovided: (a) The space and			3/8/2023 and all staff on 3/24/		
	_	space opens onto in the same			to ensure rooms without a lock	kina	
		at are protected by an			door are not used for storing	9	
		sed automatic smoke detection			combustible materials and ens	sure	
		ce with 19.3.4, and (b) Each			nursing station with a		
		by an automatic sprinklers, and			pass-through window greater t	than	
		not to obstruct access to			20 sq. inches meet the		
		S 19.3.6.5.1 states miscellaneous			requirements of spaces open t	to	
	*	nail slots, pharmacy			the corridor to meet set standa		
	1 -	ows, laboratory pass-through			b. Maintenance		
		ier pass-through windows,			Supervisor/designee will inspe	ect	
		o be installed in vision panels			all corridors throughout the fac		
		ecial protection, provided that			weekly to ensure there are no		
	both of the followin				rooms without a locking door u	ısed	
		rea of openings per room does			for storing combustibles and		
		es squared (0.015 m2).			ensure nursing stations with a		
		re installed at or below half the			pass-through window greater t		
		oor to the room ceiling.			2- sq inches meet the	16411	
		ice could affect staff and up to			requirements of spaces open t	to	
	_	smoke compartments.			the corridor as appropriate.		
	1	·	I		Land donnadi ad appropriato. II	٠	Ī

Based on observation with the Maintenance

issues are discovered, they will be

addressed and resolved

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 03/07/2023
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 F	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD DN, IN 46072	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
	nursing station, that nurses station, had a exceeding 20 squar- by an electrically st detection. Based on observation, the Ma window was greate: 2nd floor former nu with an electrically detection device.	at 3:00 p.m., the 2nd floor was no longer used as a an opening at the ceiling e inches and was not protected apervised automatic smoke interview at the time of intenance Director agreed the r than 20 square inches and the rrsing station was not provided supervised automatic smoke e reviewed with the MA during the exit conference.		immediately. The Mainten Supervisor/designee will re with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection result be presented by the Maintenance be presented by the Maintenance will present the Administrator will present the Administrator will present the inspection results at the maintenance (QA/PI) mee inspection results and syst components will be review the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensure the compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance is 3/24/2023.	ts will enance the the onthly nance ting. tem ed by ction ed as ure with ts.
K 0363 SS=E Bldg. 01	than required enc	corridor openings in other osures of vertical openings, s areas resist the passage			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/07/2023			
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072				
(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		
	solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or com Clearance betwee covering is not except doors complying wife provided with a content of the door closed what applied. There is closing of the door release when the permitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lad other 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 fire protection ratin devices, etc.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In 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 red protective plates of the permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	K363 – It is the intent of the	03/24/2023		
	failed to ensure 2 of	on and interview, the facility 2 corridor doors were ans suitable for keeping the	K 0363	K363 – It is the intent of the facility to ensure corridor door provided with a means suitabl	s are		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/07/2023	
	PROVIDER OR SUPPLIEI S OF TIPTON SKIL	LED NURSING FACILITY, THE	300 F	TADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD DN, IN 46072		
(X4) ID PREFIX		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 APPROPRI.	(X5) COMPLETION	
TAG	_	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		impediment to closing,		keeping the door closed, has		
	_	resist the passage of smoke.		impediment to closing, latchir	·	
	Inis delicient pract	rice could affect 6 residents.		and will resist the passage of smoke to meet set standards		
	Findings include:			1. CORRECTIVE ACTION TAKEN:		
	1. Based on observ	ation with the Maintenance		a. On 3/8/2023 the		
		03/07/23 at 3:25 p.m., the		Maintenance Supervisor/desi	gnee	
	corridor closet door	r by room 8 would not latch		repaired the latching mechan	-	
	into the frame when	n tested. Based on interview at		in the corridor closet door by	room	
		tion, the MA agreed the		8 so it would latch fully into th		
	corridor door would not close into the door frame.			frame to meet set standards.		
				Administrator verified the repa	airs	
		ation with the MA on 03/07/23		on 3/8/2023.		
	_	ble doors from the corridor to		b. On 3/24/2023 the		
	hardware.	lid not have positive latching		Maintenance Supervisor/desi	-	
	nardware.			installed positive latching hard to the double doors from the	dware	
	These findings wer	e reviewed with the		corridor to the Therapy Gym	·o	
		MA during the exit conference.		meet set standards. The	.0	
	Transmistrator una	on r during the one conference.		Administrator verified the repa	airs	
	3.1-19(b)			on 3/24/2023 .		
				2. ALL OTHERS WITH		
				POTENTIAL TO BE AFFECT	ED:	
			1	a. All residents and all sta		
				and visitors have the potentia		
				be affected but none were. T		
				Maintenance Supervisor/desi		
				inspected all corridor doors to		
				ensure they latch fully into the frame and for positive latching		
				hardware and found no other	-	
				negative findings.		
				3. MEASURES TO PREV	ENT	
				REOCCURRENCE:		
				a. On 3/8/2023 the		
				Administrator inserviced the		
				Maintenance Supervisor/desi	gnee	
				on the requirement that corrid	lor	
				doors latch fully into the frame	e and	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ı	JILDING	01	COMPLETED	
		155556	B. W	ING		03/07/	2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	•	300 FAI	ADDRESS, CITY, STATE, ZIP COD RGROUNDS RD I, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AV OF CORRECTION		(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	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
					have positive latching hardware meet set standards. b. Maintenance Supervisor/designee will inspectable corridor doors throughout the facility monthly to ensure they latch fully into the frame and he positive latching hardware as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/desigwill review with the Administrative 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 where presented by the Maintenan 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 to the QA/PI Committee with subsequent plans of correction developed and implemented and deemed necessary to ensure compliance is maintained.	ect ne ave a sults are ssed e gnee tor ill nce	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/07/2023	
	PROVIDER OR SUPPLIES	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD AIRGROUNDS RD N, IN 46072		
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023		
K 0712 SS=F Bldg. 01	alarm signal and conditions. Fire d and unexpected to conditions, at least The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record refailed to conduct fit quarters. LSC 19.7 conducted quarterly facility personnel (engineers, and admissignals and emergen varied conditions. all staff and resider Findings include: Based on records refassistant and the A 10:30 a.m., the foll documentation of a staff and resider and the staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider and the A 10:30 a.m., the foll documentation of a staff and resider	ay be used instead of 19.7.1.7 view and interview, the facility re drills on each shift for 2 of 4 1.6 states drills shall be y on each shift to familiarize nurses, interns, maintenance inistrative staff) with the ncy action required under This deficient practice affects	K 0712	K712 – It is the intent of the facility to ensure to conduct fire drills on each shift for all four quarters to meet set standards 1. CORRECTIVE ACTIONS TAKEN: a. On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/design on the requirement that fire drill must be conducted at unexpectimes under varying conditions least quarterly on each shift and documented to meet set standards. b. On 3/24/2023 the Maintenance Supervisor/design conducted a fire drill/training for	nee ls ited at d	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/07/2023	
	F PROVIDER OR SUPPLIE	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD NRGROUNDS RD N, IN 46072	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION drill in the fourth quarter of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) each of the three shifts and	(X5) COMPLETION DATE
	2023. Based on interview the Maintenance A completed but cout to show the aforem conducted. This finding was re-	drill in the fourth quarter of at the time of record review, ssistant stated the drills were d not find the documentation sentioned drills were eviewed with the Administrator assistant at the exit conference.		each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the drill: 3/24/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta and visitors have the potential be affected but none were. 3. MEASURES TO PREVINCE: a. Maintenance Supervisor/designee will ensufire drills are conducted at unexpected times under varyiconditions at least quarterly of each shift and documented on Fire Drill Report and that documentation be retained in facility's Life Safety Binder as part of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addressed in 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:	ED: ff I to ENT ure ing n the the a e sults are essed ne gnee
I	1		1	a The inenection results v	A/III I

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/07/2023
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Deco Combustible deco unless one of the o Flame retarda	orations orations rations shall be prohibited following is met: ant or treated with approved		be presented by the Maintens Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performar Improvement (QA/PI) meeting Inspection 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 allegation of compliance with all regulatory requirements. Our date of compliance is 3/24/2023.	e thly nce g. n by on as
	for product. o Decorations no Decorations e	neet NFPA 701. exhibit heat release less in accordance with NFPA			
	o Decorations, spaintings and other walls, ceilings and accordance with 1 o The decoration are in such limited	such as photographs, er art are attached to the non-fire-rated doors in 8.7.5.6(4) or 19.7.5.6(4). In sin existing occupancies quantities that a hazard of or spread is not present.			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X2)		· ′	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155556	B. Wl	ING		03/07/2023	
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	3			IRGROUNDS RD		
WATERS	S OF TIPTON SKILL	LED NURSING FACILITY, THE			N, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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)			DATE
	19.7.5.6						
	Based on observation	on and interview, the facility	K 0	753	K753 – It is the intent of the		03/08/2023
		f 1 corridor doors was covered			facility to ensure corridor door	s are	
		at did not exceed 30 percent of			not covered with decorations t	hat	
		.5.6 states combustible			exceed 30 percent of the door	to	
		e prohibited in any health care			meet set standards.		
	occupancy, unless of	one of the following criteria is			1. CORRECTIVE ACTION	S	
	met:				TAKEN:		
	(1) They are flame-retardant or are treated with				a. On 3/8/2023 the		
	approved fire-retardant coating that is listed and				Maintenance Supervisor/desig		
	labeled for application to the material to which it is				removed the quilt decoration t	hat	
	applied.				covered at least 40% of reside	ent	
	(2) The decorations meet the requirements of				room 11's door to meet set		
	·	rd Methods of Fire Tests for			standards. The Administrator		
		of Textiles and Films.			verified the removal on		
		exhibit a heat release rate not			3/8/2023.		
	_	when tested in accordance with			2. ALL OTHERS WITH		
		rd Method of Fire Test for			POTENTIAL TO BE AFFECTE		
		kages, using the 20 kW			a. All residents and all stat		
	ignition source.				and visitors have the potential		
		s, such as photographs,			be affected but none were. O	n	
	-	r art, are attached directly to			3/8/2023 the Maintenance		
		nd non-fire-rated doors in			Supervisor/designee inspected		
	accordance with the	_			rooms throughout the facility for		
	` '	non-fire-rated doors do not			decorations and found no other	er	
	_	peration or any required			negative findings.		
	_	and do not exceed the area			3. MEASURES TO PREVE	ENT	
	limitations of 18.7.				REOCCURRENCE:		
	· ·	not exceed 20 percent of the			a. On 3/8/2023 the		
		oor areas inside any room or			Administrator inserviced the		
		ompartment that is not			Maintenance Supervisor/desig		
	-	ut by an approved automatic			on the requirement that corrido	or	
		accordance with Section 9.7.			doors cannot be covered with		
		not exceed 30 percent of the			decorations that exceed over		
		oor areas inside any room or			percent of the door to meet se	t	
	_	ompartment that is protected			standards.		
		oproved supervised automatic			b. Maintenance		
		accordance with Section 9.7.			Supervisor/designee will inspe		
		not exceed 50 percent of the			all rooms throughout the facilit	y	
	I wall, ceiling, and do	oor areas inside patient			weekly for decorations on the		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155556	B. WI	NG		03/07/	2023
			<u> </u>	CED FEET	A DED FOR COTAL OT A TEL SID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\4/4 TED	0.05 TIDTON 01/11				RGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON	I, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	sleeping rooms hav	ing a capacity not exceeding			corridor doors as a part of the		
	four persons, in a sr	noke compartment that is			facility's Preventive Maintenar	nce	
	protected throughou	it by an approved, supervised			Program and document those		
	-	system in accordance with			inspection results as appropria		
	Section 9.7.	•			If any issues are discovered, t		
	This deficient pract	ice could affect 2 residents in			will be addressed and resolve	-	
	resident room 11.				immediately. The Maintenanc		
					Supervisor/designee will revie		
	Findings include:				with the Administrator the		
					inspection results.		
	Based on an observ	ation during a tour of the			c. The Administrator will		
		intenance Director on 03/07/23			monitor adherence to the		
		ent room 11 door was covered			Preventative Maintenance		
	-	n that covered at least 40% of			schedule and validate the		
	the door. Based on	interview at the time of the			Preventative Maintenance		
	observation, the Ma	intenance Assistant agreed			documentation is in place.		
	the corridor door wa	as partially covered with a			4. MONITORING		
	combustible decora				CORRECTIVE ACTION:		
					a. The inspection results w	/ill	
	This finding was re	viewed with the Administrator			be presented by the Maintena		
	and Maintenance A	ssistant at the exit conference.			Supervisor/designee to the		
					Administrator monthly and the		
	3.1-19(b)				Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performand	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed by		
					the QA/PI Committee with		
					subsequent plans of correction	า	
					developed and implemented a	ıs	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	n	
					all regulatory requirements.		
					Our date of compliance is		
					3/8/2023		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		·			` ′	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155556	B. WI	NG		03/07/2023	
	ROVIDER OR SUPPLIER	ED NURSING FACILITY, THE		300 FAI	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0761							
SS=F			1				
	failed to ensure annifire door assemblies accordance of LSC openings in dividing 19.1.1.4.1 shall be pshall be protected by door assemblies. (So 8.3.3.1 Openings rerating by Table 8.3. approved, listed, lab fire window assembliant hardware, including anchorage, and sills requirements of NFI and Other Opening otherwise specified states fire door assentested not less than a of the inspection by the Aldoor assemblies sha both sides to assess assembly. NFPA 80 the following items (1) No open holes of either the door or fra (2) Glazing, vision lare intact and secure equipped. (3) The door, frame noncombustible throand in working orded damage.	19.1.1.4.1.1 communicating g fire barriers required by permitted only in corridors and by approved self-closing fire ee also Section 8.3.) LSC quired to have a fire protection 4.2 shall be protected by peled fire door assemblies and blies and their accompanying all frames, closing devices, in accordance with the PA 80, Standard for Fire Doors Protectives, except as in this Code. NFPA 80 5.2.1 mblies shall be inspected and annually, and a written record all be signed and kept for HJ. NFPA 80, 5.2.4.1 states fire ll be visually inspected from the overall condition of door 1, 5.2.4.2 states as a minimum, shall be verified: r breaks exist in surfaces of ame. Light frames, and glazing beads ely fastened in place, if so the protection of the condition of door and the protection of the place, if so the place, if so the place, if so the place, aligned, are with no visible signs of	K 0'	761	K761 – It is the intent of the facility to ensure annual inspectand testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted of in corridors and shall be protected by approved self-closing fire diassemblies to meet set standards. 1. CORRECTIVE ACTIONSTAKEN: a. On 3/8/2023 the Maintenance Supervisor/design conducted the annual inspection for the fire door assemblies and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on 3/8/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. 3. MEASURES TO PREVERECCURRENCE: a. On 3/8/2023 the Administrator/corporate Proper Manager inserviced the	.1 Dy polly cted coor S gnee con and ED: ff to ENT	03/08/2023
	(4) No parts are mis	sing or broken. do not exceed clearances			Maintenance Supervisor/desig on the requirement that annua	· I	
	listed in 4.8.4 and 6.				testing & inspections of fire do		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	. BUILDING <u>01</u>		COMPLETED	
		155556	B. WI	NG		03/07/2023	
			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(ED NUDCING FACILITY THE			IRGROUNDS RD		
WATERS	S OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON	N, IN 46072		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(6) The self-closing	g device is operational; that is,			assemblies must be conducte	d to	
	the active door con	apletely closes when operated			ensure proper operation and		
	from the full open				documented on the Annual Do	oor	
	(7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the				Inspections log to meet set		
					standards.		
					b. Maintenance		
	door when it is in the closed position.				Supervisor/designee will cond	uct	
		vare items that interfere or			the annual inspection of fire de		
		are not installed on the door or			assemblies to ensure proper		
	frame.				operation and document the		
	(10) No field modifications to the door assembly				inspection results on the Annu	ıal	
	have been performed that void the label.				Door Inspection log as a part		
	(11) Gasketing and edge seals, where required, are				the facility's Preventive	J.	
	inspected to verify their presence and integrity.				Maintenance Program and		
	This deficient practice could affect all residents.				document those inspection re-	sults	
	Time delicitori praes				as appropriate. If any issues		
	Findings include:				discovered, they will be addre		
	i mamga meraac.				and resolved immediately. Th		
	Based on record rev	view with the Maintenance			Maintenance Supervisor/desig		
		03/07/23, no current			will review with the Administra		
		n annual inspection for the fire			the inspection results.	itoi	
		as available for review. The last			c. The Administrator will		
		inspection was completed in			monitor adherence to the		
		interview at the time of records			Preventative Maintenance		
		tion, the MA stated the annual			schedule and validate the		
		was not completed within the			Preventative Maintenance		
	last year.	was not completed within the			documentation is in place.		
	last year.				4 1401117001110		
	This finding was re	viewed with the Administrator			CORRECTIVE ACTION:		
	and MA at the exit				l <u>-</u>	vill	
	and WA at the exit	conference.			· ·		
	3.1-19(b)				be presented by the Maintena Supervisor/designee to the	IIO C	
	3.1-17(0)				Administrator monthly and the		
					-	•	
					Administrator will present the	alv	
					inspection results at the month	-	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	оу	
					the QA/PI Committee with		

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		IDENTIFICATION NUMBER 155556	A. BUILE B. WING		01	COMPLETED 03/07/2023	
	PROVIDER OR SUPPLIER	ED NURSING FACILITY, THE	3	00 FAII	DDRESS, CITY, STATE, ZIP COD RGROUNDS RD , IN 46072		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					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 3/8/2023.	S	
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, results. Additional testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch activates both visual LIM circuits with an annual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the effectors are maintages associated repairs containing date, regults. 6.3.4 (NFPA 99)	s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. Is performed at intervals ented performance data. Is tested as hospital-grade at the tested at intervals not withs. Line isolation monitors are tested at intervals of to 1 month by actuating to per 6.3.2.6.3.6, which wal and audible alarm. For utomated self-testing, this formed at intervals less to months. LIM circuits are a after any repair or electric distribution system. It tained of required tests and to or modifications, form or area tested, and	K 001	1	K914 It is the intent of the fac	ility	03/08/2023
	Based on record rev	new and interview, the facility	K 0914	4	K914 – It is the intent of the fac	ility	03/08/2023

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155556	B. W	ING		03/07/2	2023
NAME OF D	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					IRGROUNDS RD		
WATERS	OF TIPTON SKILL	LED NURSING FACILITY, THE		TIPTON	N, IN 46072		
(X4) ID		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	TE.	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		-hospital grade electrical			to ensure nonhospital grade	·	
	-	ent sleeping rooms were tested			electrical receptacles in reside		
		FPA 99, Health Care Facilities			sleeping rooms are tested at I		
		Section 6.3.4.1.3 states			annually to meet set standard		
	-	d as hospital-grade, at patient			1) CORRECTIVE ACTIONS	·	
		locations where deep			TAKEN:		
	•	anesthesia is administered,			a) On 3/8/2023 The		
		tervals not exceeding 12			Administrator inserviced the		
		lly, Section 6.3.3.2, Receptacle fare Rooms requires the			Maintenance Supervisor on the		
	_	are Rooms requires the feach receptacle shall be			requirement to test non-hospit	iai	
		l inspection. The continuity of			grade electrical receptacles		
	-	it in each electrical receptacle			installed in resident sleeping rooms throughout the building		
		orrect polarity of the hot and			, , ,		
		in each electrical receptacle			annually to meet set standard b) On 3/8/2023 the	s.	
		and retention force of the			b) On 3/8/2023 the Maintenance Supervisor/desig	nee	
		each electrical receptacle			conducted the annual inspecti		
		e receptacles) shall be not less			of the non-hospital grade elec		
		ounces). This deficient practice			receptacles installed in reside		
	could affect all resid	·			sleeping rooms throughout the		
	25414 411001 411 10510				building and documented the	_	
	Findings include:				results on the Annual Recepta	acle	
					Testing Log to meet set		
	Based on records re	view with the Maintenance			standards. The Administrator		
		3/7/23 at 11:30 a.m., no			verified the inspections and		
		available to show that testing			documentation on 3/8/2023 .		
		eptacles in resident sleeping			2) ALL OTHERS WITH		
		ed during the last 12 months.			POTENTIAL TO BE AFFECTI	ED:	
	•	at the time of the record			a) All residents and all sta		
	review, the Mainten	nance Assistant confirmed all			and visitors have the potential	to	
		acles in the resident sleeping			be affected but none were.		
	_	pital-grade and stated it is			3) MEASURES TO PREVE	NT	
	unknown the last tir	ne the annual testing was			REOCCURRENCE:		
	completed.				a) On 3/8/2023 the		
					Administrator inserviced the		
	This finding was re-	viewed with the Administrator			Maintenance Supervisor/desig	gnee	
	and MA during the	exit conference.			on the requirement that		
					non-hospital grade electrical		
	3.1-19(b)				receptacles in resident sleepir	ng	
					rooms must be tested annuall	y	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/07/2023	
	ROVIDER OR SUPPLIES OF TIPTON SKIL	R LED NURSING FACILITY, THE	300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072		
(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	
				and documented on the Annu Receptacle Testing Log to me set standards. b) Maintenance Supervisor/designee will ensure properly test non-hospital grade electrical receptacles installed resident sleeping rooms throughout the building annual as part of the facility's Prevent Maintenance Program and document those inspection reson the Annual Receptacle Test Log as appropriate. If any issuare discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the month of the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) The inspection results where the month of the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: be presented by the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: be presented by the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: be presented by the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: be presented by the Maintenance documentation is in place. 4) MONITORING CORRECTIVE ACTION: be presented by the Maintenance documentation is in pl	al pet do de	

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	of correction (155556) Tip Provider/supplier/clia	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/07/2023			
	PROVIDER OR SUPPLIER S OF TIPTON SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Bille			
			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 3/8/2023.				
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility	K 0920	K920 – It is the intent of the	03/24/2023			
	failed to ensure 1 of 1 power strips were not used	K 0920	facility to ensure power strips				

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 03/07/2023 155556 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 FAIRGROUNDS RD WATERS OF TIPTON SKILLED NURSING FACILITY, THE **TIPTON. IN 46072** (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 as a substitute for fixed wiring to provide power not used as a substitute for fixed equipment with a high current draw. wiring to provide power equipment NFPA-70/2011, 400.8 state unless specifically with a high current draw to meet permitted in 400.7 flexible cords and cables shall set standards. not be used for (1) as a substitute for fixed wiring. 1.CORRECTIVE ACTIONS This deficient practice could affect up to 5 TAKEN: residents in the Activity office area. 1.On 3/8/2023 the Maintenance Supervisor/designee Findings include: removed the power strip from the Activity office that was being used Based on observations during a tour of the facility to power a refrigerator to meet set with the Maintenance Assistant (MA) on 03/07/23 standards. The Administrator at 4:00 p.m. a refrigerator (high power draw verified the removal on 3/8/2023 equipment) was plugged into and supplied power by a power strip in the Activity office. Based on 2.ALL OTHERS WITH interview at the time of observation, the POTENTIAL TO BE AFFECTED: Maintenance Assistant acknowledged a power 1.All residents and all staff strip was supplying power to high power draw and visitors have the potential to equipment. be affected but none were. On 3/8/2023 the Maintenance This finding was reviewed with the Administrator Supervisor/designee inspected all and MA at the exit conference. rooms throughout the facility for power strips and found no other 3.1-19(b)negative findings. **3.MEASURES TO PREVENT** REOCCURRENCE: 1.On 3/8/2023 the Administrator inserviced the Maintenance Supervisor/designee/ and on 3/24/2023 all other staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not

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have power strips in use as a part

of the facility's Preventive Maintenance Program and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155556				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
					01	COMPLETED		
		B. WING			03/07/	/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
K 0923	NFPA 101				document those inspection resas appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrator the inspection results. 3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECT ACTION: 1. The inspection results to be presented by the Maintenan 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 3/24/2023.	are ssed he gnee tor IVE will nce hly ce by n as		
SS=E		Cylinder and Container						
Bldg. 01	Storag	Symmod and Container						
							i	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER 155556		A. BUILDING 01 B. WING		COMPLETED 03/07/2023				
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 FAIRGROUNDS RD TIPTON, IN 46072					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION Cylinder and Container		TAG	DEFICIENCY)		DATE	
	Storage Greater than or ed	ual to 3,000 cubic feet						
	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.							
	>300 but <3,000 c Storage locations	ubic feet are outdoors in an						
	enclosure or withir	n an enclosed interior						
	space of non- or limited- combustible construction, with door (or gates outdoors)							
	that can be secured. Oxidizing gases are not stored with flammables, and are separated							
l		by 20 feet (5 feet if closed in a cabinet of						
	noncombustible co	onstruction having a						
	Less than or equa							
	-	compartment, individual for immediate use in						
		with an aggregate volume all to 300 cubic feet are not						
	required to be stor	ed in an enclosure.						
	as specified in 11.							
		gn readable from 5 feet is ate of a cylinder storage						
		ign includes the wording as TION: OXIDIZING GAS(ES)						
	STORED WITHIN	• •						
	order of which the	y are received from the						
		ylinders are segregated When facility employs						
	-	gral pressure gauge, a e considered empty is						
	established. Emp	ty cylinders are marked to Cylinders stored in the open						
	are protected from	· · · · · · · · · · · · · · · · · · ·						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155556		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/07/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF TIPTON SKILLED NURSING FACILITY, THE					300 FA	ADDRESS, CITY, STATE, ZIP COD IRGROUNDS RD N, IN 46072		
	(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 APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
		failed to ensure emp segregated from ful avoid confusion. The affect up to 15 reside compartment. Findings include: Based on observation Assistant (MA) on the oxygen storage room separate full cylinder Based on interview MA stated that there section designated in	ons with the Maintenance 03/07/23 at 3:50 p.m. in the m there was no means to ers from empty cylinders. at the time of observation, the e was no empty cylinder in the oxygen storage room.	K 0	923	K923 – It is the intent of the facility to ensure empty oxyge cylinders are segregated from cylinders and are marked to a confusion to meet set standar 1. CORRECTIVE ACTION TAKEN: a. On 3/23/2023 the Director of Nursing/designee installed signage in the Oxygen Storag Room to separate full cylinder from empty cylinders to meet standards. The Administrator verified the work on 3/23/2023 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTION a. All residents and all star and visitors have the potential be affected but none were. Of 3/23/2023 DON/designee che all areas of the facility for improperly stored oxygen cylinders and found no other negative findings. 3. MEASURES TO PREVIOUS REOCCURRENCE: a. On 3/8/2023 the Administrator inserviced the DON/designee and on 3/24/20 all other nursing staff on the requirement that empty oxyge cylinders must be segregated full cylinders and marked to acconfusion to meet set standar b. The Director of Nursing/designee will inspect oxygen cylinders weekly to enthe empty cylinders are segregated from the full cylinders segregated from the full cylinders enterprised from	tofull void ds. IS tor esset ED: ff to n cked ENT D23 en from void ds. all esure	03/24/2023

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OF CORRECTION	IDENTIFICATION NUMBER 155556	A. BUILDING B. WING	01	COMPI 03/07	LETED
ROVIDER OR SUPPLIEI OF TIPTON SKILI		300 FA	ADDRESS, CITY, STATE, ZIP IRGROUNDS RD N, IN 46072	COD	
S OF TIPTON SKILLED NURSING FACILITY, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	300 FA	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) as a part of the facility Policy and Procedure and document those i issues are discovered addressed and resolv immediately. The Ma Supervisor/designee with the Administrator inspection results. c. The Administrator inspection results. c. The Administrator Policy & Procedures of validate the Oxygen of Procedures are in pla 4. MONITORING CORRECTIVE ACTION a. The inspection be presented by the of Supervisor/designee Administrator monthly Administrator will prese Administrator wi	DERIS PLAN OF CORRECTION DECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY) If the facility's Oxygen Procedures Program Dent those inspection Despropriate. If any D		
			inspection results at t Quality Assurance/Pe Improvement (QA/PI) Inspection results and components will be re the QA/PI Committee subsequent plans of developed and impler deemed necessary to compliance is maintal. This plan of correcti- constitutes our cred allegation of complia all regulatory require Our date of complian 3/24/2023.	the monthly erformance) meeting. d system eviewed by with correction mented as o ensure ined. ion lible ance with ements.	

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