STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  X3) DATE SURVEY  COMPLETED  02/24/2023		
	PROVIDER OR SUPPLIER S OF DILLSBORO-ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018		
(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)	(X5) COMPLETION DATE
E 0000				
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date(s): 02/23/23 & 02/24/23  Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840  At this Emergency Preparedness survey, The Waters of Dillsboro-Ross Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  The facility has 123 certified beds. At the time of the survey, the census was 65.  Quality Review completed on 03/06/23	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance will rederal Medicare and Medicaid requirements.  We respectfully request a dereview for compliance.	t the set red ce on
K 0000				
Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date(s): 02/23/23 & 02/24/23  Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific	t the

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ſ ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	02	COMPLETED
		155280	B. W	'ING		02/24/2023
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD	
\\\\	OF DILL SPARA	DOSS MANIOD THE			LENOVER ST	
WATERS	OL DIFF2ROKO-P	ROSS MANOR, THE		DILLSE	3ORO, IN 47018	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION SHOULD BE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG		DATE
		Code survey, The Waters of			corrective actions are prepar	
	Dillsboro-Ross Manor was found not in compliance with Requirements for Participation in				and/or executed in complian with state and federal laws.	ce
	-	, 42 CFR Subpart 483.90(a),			This plan of correction	
		re and the 2012 edition of the			constitutes a written allegati	on
	-	etion Association (NFPA) 101,			of substantial compliance wi	
		Chapter 19, Existing Health Care			Federal Medicare and	
	Occupancies and 41				Medicaid requirements.	
•						
	The Waters of Dills	boro-Ross Manor consisted of			We respectfully request a de	sk
	-	ngs. The Waters of Dillsboro,			review for compliance.	
	•	o-story facility with a basement				
		to be of Type V (000)				
		lly sprinklered. Ross Manor,				
	-	e-story facility and was				
		ype V (111) construction and				
		Both facilities have a fire alarm				
	*	detection on all levels of the				
		building and Ross Manor				
		he corridors, spaces open to as battery operated smoke				
		lent sleeping rooms in the				
		building and the Ross Manor				
		ers of Dillsboro-Ross Manor				
	-	3 and had a census of 65 at				
	the time of this visit					
	All areas where resi	dents have customary access				
	*	all areas providing facility				
	services were sprink	klered.				
	Quality Review con	npleted on 03/06/23				
K 0100	NFPA 101					
SS=F	General Requirem	nents - Other				
Bldg. 02	General Requirem					
	· ·	RKS section any LSC				
		19.1 General Requirements				
		ssed by the provided				
	K-tags, but are deficient. This information,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155280			LDING	nstruction  02	(X3) DATE COMPI <b>02/24</b>		
WATERS	PROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION ILD BE ROPRIATE	(X5) COMPLETION DATE
	along with the app NFPA standard ci on Form CMS-256 Based on observation failed to ensure 1 of and operated to mire emergency requiring LSC Section 19.1.1 facilities shall be domaintained, and open possibility of a fire evacuation of occup states because the standard staff; and domaintenance on evacuation from fire appropriate arrange trained staff; and domaintenance process following:  (1) Design, constructive (2) Provision for de extinguishment  (3) Fire prevention training, and drilling fire, transfer of occup evacuation of the bundle occupancies shall be portions of other occupancies shall be portions of other occupancies shall in occupancies shall in occupancies shall in	election, should be included for an and interview, the facility of a fire generated to minimize the possibility of a fire generated to minimize the emergency requiring the pants. LSC Section 19.1.1.3.2 after of health care ensured adequately by enation of the building, their eshall be provided by ment of facilities; adequate, evelopment of operating and dures composed of the etion, and compartmentation tection, alarm, and procedures and planning, generated to areas of refuge, or	K 01	TAG	The facility is requesting for this and will have an F survey conducted.	a waiver	
	Findings include:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155280	B. W	NG		02/24/	2023
	ROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	I C	DATE
K 0161 SS=F Bldg. 02	Director during a to a.m. to 2:45 p.m. on separated from the floor joists in the ea which classifies the building as Type V the basement consist combustible item storage. These findings were Administrator and tiduring the exit confidence of the construct Building Construct Building Construct 2012 EXISTING Building construct Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5	tion Type and Height tion Type and Height tion Type and Height tion type and stories meets less otherwise permitted by 9.1.6.7					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER S OF DILLSBORO-F	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	3 II (000) non-sprinklered 4 III (211) sprinklered 5 IV (2HH) 6 V (111) 7 III (200) non-sprinklered 8 V (000) sprinklered 8 V (000) sprinklered Sprinklered storie throughout by an automatic system 9.7. (See 19.3.5) Give a brief descr construction, the respective of the seements, floors located, location of dates of approval small floor plan of 1. Based on observative failed to ensure 1 of a 1 hour rated floor building construction two-story building floor/ceiling asseminated a one-hour fire resist of the first-floor conbasement space and fire rating. This deresidents who reside building.  Findings include:  Based on observative Director during a total sprince of the first-floor conbasement space and fire rating. This deresidents who reside building.	Not allowed  Maximum 2 stories	K 0161	The facility is requesting a temporary waiver and will have FSES survey conducted and achieve a passing score.	07/02/2023
	_	first floor with exposed wood			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155280		r í	UILDING	onstruction 02	(X3) DATE COMPL 02/24/	ETED	
	PROVIDER OR SUPPLIER S OF DILLSBORO-F	ROSS MANOR, THE	•	12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	southwest basement northwest basement which classifies the building as Type V the time of the obset Director stated the structure one-half inch plywouthroughout the first material. The baser construction was construction and the during the exit confideration of the second-floor ceiling ensure the attic has barrier walls extend roof. LSC Section smoke barrier shall with Section 8.5 and 1/2-hour fire resistant permitted by one of (1) This requirement atrium is used, and also shall apply:  (a) Smoke barriers at an atrium wall construction wall construction wall construction.	reviewed with the he Maintenance Director Ference.  Treview, observation and ty failed to provide he fire resistance rating of the gramma smoke barrier construction to the required number of smoke ling to the underside of the 19.3.7.3 states any required be constructed in accordance dishall have a minimum nnce rating, unless otherwise of the following:  It shall not apply where an both of the following criteria shall be permitted to terminate constructed in accordance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 Լ	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	_
(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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	heating, ventilating, where an approved, sprinkler system in been provided for sit to the smoke barrier Section 8.5.2.1 state this Code shall be cwall to an outside with from a smoke barrier of a combination the smoke barriers shall concealed spaces, sit ceiling, including in 8.5.2.3 states smoke shall be continuous outside wall, from a smoke barrier to a sit combination thereous shall comply with of (1) The fire barriers wall to outside wall another, or a combination thereous the state of the fire barriers wall to outside wall another, and from the interstitial space, proceedings assembly forming the space has a fire resist that of the fire barriers that of t	and air-conditioning systems supervised automatic accordance with 19.3.5.8 has moke compartments adjacent as smoke barriers required by continuous from an outside vall, from a floor to a floor, or are to a smoke barrier, or by use ereof. Section 8.5.2.2 states a be continuous through all such as those found above a atterstitial spaces. Section a barriers required by this Code from an outside wall to an afloor to a floor, or from a moke barrier, or by use of a f. Section 8.3.1.2* Fire barriers ne of the following: are continuous from outside or from one fire barrier to nation thereof, including all concealed spaces, such as a ceiling, including interstitial are continuous from outside or from one fire barrier to the floor to the bottom of the ovided that the construction are bottom of the interstitial stance rating not less than			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING					
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	STREET ADDRESS, CITY, STATE, ZIP COD  12803 LENOVER ST  DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
K 0211 SS=E Bldg. 02	was also not available observations with the during a tour of the p.m. on 02/24/23, the barrier and fire barrier and fire barrier and fire barrier walls the roof deck above.  This finding was retard the Maintenance conference.  3.1-19(b)  NFPA 101  Means of Egress - Means of Egress - Aisles, passageward discharges, exit low 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 3 of continuously maintator impediments to fire or other emergency of the fir	General General Age, corridors, exit Cations, and accesses are Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2  110.1 In and interview, the facility 14 means of egress was ained free of all obstructions ull instant use in the case of ney. This deficient practice a residents, staff and visitors if	K 0211	It is the intent of the facility to ensure means of egress are continuously maintained free o obstructions or impediments to instant use in the case of fire o other emergency to meet set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 2/24/23 the Maintenance Supervisor/desig removed the wheeled cart and	full r		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY  COMPLETED  02/24/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	n 02/24/23, the following was		cooler outside the second-flo	= :
	noted:	lled in a wheeled cart projected		activity director's office by roo	l l
		orridor outside the second		cart outside the second-floor	ileu
		etor's office by Room 53. A		activity director's office by roo	om 53
	I	t which projected 18 inches		to meet set standards.	5111 00
		as also stored in the corridor		b. On 2/27/23 the	
		floor Activity Director's office		Maintenance Supervisor/desi	ignee
		corridor width at the second		removed the chains attached	-
	1 -	etor's office by Room 53		the stairwell handles in the	
	I	. Each measurement taken was		second-floor stairwell by the	new
	made with the Mair	ntenance Director's measuring		elevator by room 27 to meet	
	tape.			standards.	
	b. chains attached to	o the stairwell handrails were		c. By 4/7/23 the Maintena	ance
	used to block the m	eans of egress in the		Supervisor/designee repaired	d the
	second-floor stairw	ell by the new elevator by		door lock at the exit door in the	ne
	Room 27.			Alzheimer's Activities room to	
		ne Alzheimer's Activities room		meet set standards.	
	was marked as a fac	cility exit with an exit sign and		2. ALL OTHERS WITH	
		entering a four-digit code.		POTENTIAL TO BE AFFECT	ED:
		pirector entered the code to		a. All residents and all sta	aff
		open multiple times, but it		and visitors have the potentia	l l
		second to open the door		be affected but none were. C	On
	before relocking.			2/24/23 the Maintenance	
	Based on interview			Supervisor/designee inspecte	
		aintenance Director agreed		corridor means of egress and	
		means of egress was not		found no other negative finding	
	I -	ned free of all obstructions or		3. MEASURES TO PREV	ENI
		instant use in the case of fire		REOCCURRENCE:	
	or other emergency	•		a. On 3/24/23 the	
	These findings were	e reviewed with the		Administrator inserviced the Maintenance Supervisor/desi	ignee
		he Maintenance Director		and all other staff on the	igno <del>s</del>
	during the exit conf			requirement that the corridor	
	and the exit com			means of egress are to rema	in
	3.1-19(b)			free of obstructions to meet s	
				standards.	
				b. Maintenance	
				Supervisor/designee will insp	ect
				all corridor means of egress	

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/24/2023	
	ROVIDER OR SUPPLIED	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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
				throughout the facility weekly obstructions as a part of the facility's Preventive Maintenan Program and document those inspection results as appropri If any issues are discovered, will be addressed and resolve immediately. The Maintenand 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 to be presented by the Maintenance Supervisor/designee to 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 4/7/23.	will ance  hly ce  j. hby h

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280		A. BUILDING B. WING	<u></u>		COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 Լ	ADDRESS, CITY, STATE, ZIP CO LENOVER ST BORO, IN 47018	DD .		
(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 SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 0222 SS=E Bldg. 02	be equipped with a requires the use of egress side unless special locking arr. CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carricother such reliable staff at all times.  18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended lock space); and both the control of the contro	king arrangements for the eds of the patient are king device shall be door and provisions shall spid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1,  LOCKING Sking arrangements for the expatient are used, all of urity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised or system and the locked by a complete smoke or is constantly monitored action within the locked he sprinkler and detection ged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING					

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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>02</u> COMPL				
		155280	B. W	ING		02/24/	2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	•	12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE		
	Approved, listed d	elayed-egress locking					
	systems installed in accordance with						
	7.2.1.6.1 shall be	permitted on door					
	assemblies servin	g low and ordinary hazard					
	contents in buildin	gs protected throughout by					
	an approved, supe	ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2.	2.4					
	ACCESS-CONTR	OLLED EGRESS					
	LOCKING ARRAN	NGEMENTS					
	Access-Controlled Egress Door assemblies						
	installed in accordance with 7.2.1.6.2 shall						
	be permitted.						
	18.2.2.2.4, 19.2.2.						
	ELEVATOR LOBE						
	LOCKING ARRAN						
	1	t access door locking in					
		2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2.		77.0	222			04/05/2022
		on and interview, the facility	K 0	222	It is the intent of the facility to		04/07/2023
		means of egress through 8 of			ensure the means of egress		
		y accessible for residents			through exits are readily		
		agnosis requiring specialized			accessible for residents withou	ıı a	
	1	Doors within a required means			clinical diagnosis requiring	to	
	_	be equipped with a latch or the use of a tool or key from the			specialized security measures meet set standards.	ιο	
	_	therwise permitted by LSC				2	
		Door-locking arrangements			1. CORRECTIVE ACTIONS TAKEN:	3	
		n accordance with 19.2.2.2.5.2.					
		ice could affect over 50			a. On 3/17/23 the  Maintenance Supervisor/desig	nee	
	·	visitors if needing to exit the			posted information on how to	1100	
	facility.	rishers it needing to exit the			obtain the correct code at the	≏vit	
	idenity.				door to the outside of the facili		
	Findings include:				on the second floor by Room 5	-	
	i mamga matata.					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	02	COMPL	ETED
		155280	B. W	ING		02/24/	2023
				CED DET	ADDRESS OF A STATE SID SOD		
NAME OF	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED/		DOCC MANOR THE			LENOVER ST		
WATER	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSE	BORO, IN 47018		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\L	DATE
					meet set standards.		
	Based on observation	ons during the initial walk			b. On 3/17/23 the		
		ity at 9:55 a.m. on 02/23/23, the			Maintenance Supervisor/desi	anee	
	_	side of the facility on the			posted information on how to		
		om 55 was marked as a facility			obtain the correct code at the	exit	
		n and could be opened by			door to the outside of the faci		
	_	t code at a keypad near the			on the first floor by the Therap	-	
		ct code was posted. Based on			Room and removed the no ex	-	
		e of the observations, the			sign to meet set standards.	· · ·	
		tor stated not all residents on			c. On 3/17/23 the		
		ve a clinical diagnosis to be in			Maintenance Supervisor/desi	anee	
		greed the posted code to			posted information on how to	grice	
	_	open was not the correct code.			obtain the correct code at the	ovit	
		Pirector stated the facility did			door to the outside of the faci		
		noke in this exit discharge			on the first floor inside the Th	-	
		the adjoining part of the			Room and removed the no ex		
		observations with the			sign to meet set standards.	ΛIL	
	_	tor during a tour of the facility			d. On 3/17/23 sign on the	firet	
		2:15 p.m. on 02/24/23, the			floor inside the stairwell by ro		
	following was noted				to meet set standards.	OIII 1	
	_	e was still posted at the exit			e. On 3/17/23 the		
	door by Room 55 o	-			Maintenance Supervisor/desi	anoo	
	-	he outside of the facility on the			removed the no exit sign on the	-	
		herapy Room was marked as a			first floor by the Business Offi		
	-	exit sign. The door also had an			meet set standards.	CE IO	
	· ·	. The door could be opened by			f. On 3/17/23 the		
	1	t code at a keypad by the exit			Maintenance Supervisor/desi	anoo	
		ect code to open the door was			posted information on how to	griee	
	posted.	ect code to open the door was			obtain the correct code at the	ovit	
	1 ^	ne outside of the facility on the					
		Therapy Room was marked as			door to the outside of the faci on the first floor in the Lenove	-	
		an exit sign. The door also had					
	I	ign. The door could be opened			Dining Room and removed the		
		ligit code at a keypad by the			exit sign to meet set standard	اح.	
					g. On 3/17/23 the	anaa	
		correct code to open the door			Maintenance Supervisor/designated information on how to	griee	
	was posted.	ha autaida af tha facilitae an tha			posted information on how to		
		he outside of the facility on the			obtain the correct code at the		
		e stairwell by Room 7 was			door to the outside of the faci	-	
	marked as a facility	exit with an exit sign. The	I		on the first floor by room 64 a	nd	

door also had an affixed no exit sign.

removed the no exit sign to meet

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CI	ENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039	
	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPL	LETED	
			155280	B. WING		02/24	/2023	
_				<del></del>				
	NAME OF P	ROVIDER OR SUPPLIER	8		T ADDRESS, CITY, STATE, ZIP COD			
				12803 LENOVER ST				
WATERS OF DILLSBORO-ROSS MANOR, THE		DILLS	SBORO, IN 47018					
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
	PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
	TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
			ne outside of the facility on the	1110	set standards.		5.112	
			siness Office was marked as a		h. On 3/17/23 the			
		-	exit sign. The door also had an			2000		
		-			Maintenance Supervisor/designation on hourse	gnee		
		affixed no exit sign.			posted information on how to	.,		
			o the outside of the facility on		obtain the correct code at the			
			Lenover Dining Room was		door to the outside of the faci	-		
		-	exit with an exit sign. The		on the second floor by the fre	-		
			affixed no exit sign. The door		elevator to meet set standard	S.		
			by entering a four-digit code		2. ALL OTHERS WITH			
			exit door set but the incorrect		POTENTIAL TO BE AFFECT	ED:		
		code to open the do			a. All residents and all sta	ff		
		g. the exit door set t	to the outside of the facility on		and visitors have the potentia	l to		
		the first floor by Ro	om 64 was marked as a facility		be affected but none were. C	)n		
		exit with an exit sig	n. The door set also had an		3/17/23 the Maintenance			
		affixed no exit sign.	. The door set could be opened		Supervisor/designee inspecte	d all		
		by entering a four-d	ligit code at a keypad by the		doors to ensure information o			
			incorrect code to open the		how to obtain the codes was			
		door set was posted	_		present and found no other			
		-	he second floor by the freight		negative findings.			
			d as a facility exit with an exit		3. MEASURES TO PREV	FNT		
			pened by entering a four-digit		REOCCURRENCE:			
		-	the exit door but the incorrect		a. On 3/24/23 the			
		code to open the do			Administrator inserviced the			
		-	for entered what he said was		Maintenance Supervisor/desi	anoo		
			release the door to open, but it		•	griee		
			ne exit door released with fire		and all other staff on the			
		•			requirement that information to			
			ation by use of a manual fire		obtain the codes must be pos	iea		
		alarm box at 12:12	p.m.		at the exit doors to meet set			
		m			standards.			
			e reviewed with the Executive		b. Maintenance			
			or of Maintenance, and the		Supervisor/designee will insp			
		Housekeeping Man	ager during the exit		all means of corridor doors we	-		
		conference.			to ensure they have informati			
					how to obtain the codes as a	part		
		3.1-19(b)			of the facility's Preventive			
					Maintenance Program and			
					document those inspection re	sults		
					as appropriate. If any issues			
					discovered, they will be addre			
					, ,			

and resolved immediately. The

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155280	B. WI	B. WING		02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	•	12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					Maintenance Supervisor/design will review with the Administrate the inspection results.  c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. MONITORING CORRECTIVE ACTION:  a. The inspection results who be presented by the Maintenan Supervisor/designee to 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 4/7/23.	rill nce nly ce	
K 0225 SS=E Bldg. 02	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4,	okeproof Enclosures okeproof Enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 ution and interview, the facility	K 02	225	It is the intent of the facility to		04/07/2023

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

Event ID:

Z6R521

Facility ID: 000178

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		A. BUILDING <u>02</u>		COMPI	x3) DATE SURVEY COMPLETED 02/24/2023		
	PROVIDER OR SUPPLIER		•	12803 I	ADDRESS, CITY, STATE, ZIP COD LENOVER ST	•	
WATERS	OF DILLSBORO-F	ROSS MANOR, THE		DILLSE	BORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f 2 exterior stairs comply with			ensure exterior stairs comply		
	•	7.2.2.3.3.1. Section 7.2.2.3.3.1			the requirements of 7.2.2.3.3		
		and landings shall be solid,			and to ensure items stored in		
	-	s. Section 7.2.2.3.3.2 states:			escape stairways will not inte		
		dings shall be free of hat could trip stair users. This			with egress and to ensure ite	ms	
		ould affect over 20 residents,			stored in interior fire escape	with	
	_	needing to exit the facility.			stairways would not interfere		
	starr and visitors in	needing to exit the facility.			egress to meet set standards  1. CORRECTIVE ACTION		
	Findings include:				TAKEN:	10	
	i manigo metade.				a. On 3/17/23 the		
	Based on observation	ons with the Maintenance			Maintenance Supervisor/des	anee	
		our of the facility from 10:20			consulted with an engineer a	_	
	_	a 02/24/23, the facility exit by the			researched and found out that		
	_	door by Room 7 was marked			area does not need to be an		
		th an exit sign. The exterior			emergency exit. The area in		
		y exit was metal construction			question already has two sta	rwell	
		and treads. In addition, the			exits that lead to the outside.		
	facility exit on the s	second floor by Room 26 was			Maintenance Supervisor/des	gnee	
	also marked as a fac	cility exit with an exit sign. The			will remove the exit sign and	J	
	exit door led to a ro	of which covered the sidewalk			install a No Exit sign at the d	oors	
	below. An exterior	stairs for the facility exit was			located by rooms 7 and 26 to	1	
	attached to the roof	The stairs were of metal			meet set standards.		
		nt solid risers and treads. The			b. By 4/7/23, the Mainten	ance	
		f the stairs is the roof deck.			Supervisor/designee remove	d the	
		the stairs creates a riser			extension ladder, bags of ro		
		inches higher than the plane of			salt and a wood beam from t	ne	1
		creating a tripping hazard. A			enclosed stairwell in the exit		
	_	ced on top of the riser. Based			discharge by room 55 on the		
		time of the observations, the			second floor to meet set		
		tor agreed the aforementioned			standards.		
		solid risers and treads and an			c. By 4/7/23, the Mainten		
		n place for the stairs at the top			Supervisor/designee remove		1
	of the landing.				storage items from undernea		
	Those findings	a ravious d with the			attic stairwell by the Pantry b	•	
	These findings were	he Maintenance Director			room 51 on the second floor	iO	
	during the exit conf				meet set standards.		
	during the exit conf	CICICC.			2. ALL OTHERS WITH	ED:	
	3.1-19(b)				POTENTIAL TO BE AFFECT		

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMI	3 NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLE	ETED
		155280	B. WING		02/24/2	2023
NAME OF I	PROVIDER OR SUPPLIER	t		ADDRESS, CITY, STATE, ZIP COD		
\A/A TED/	0.0000000000000000000000000000000000000	DOOD MANOR THE		LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE	DILLSE	3ORO, IN 47018		
(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)	VIE.	DATE
				and visitors have the potential	to	
	2. Based on observa	ation and interview, the facility		be affected but none were.		
		ns stored in 1 of 3 fire escape		3. MEASURES TO PREVE	ENT	
		t interfere with egress. LSC		REOCCURRENCE:		
	-	states open space within the		a. On 3/24/23 the		
		not be used for any purpose		Administrator inserviced the		
		al to interfere with egress.		Maintenance Supervisor/desig	nnee	
	_	ice could affect 10 residents,		on the requirement that interior		
	_	ing the enclosed exit stairwell		escape stairwells must be free		
	by Room 55 on the			impediments and all exterior e		
	by Room 33 on the	second moor.		must be free of projections to	AILO	
	Findings include:			meet set standards.		
	rindings include.					
	Događ om obsamjetic	ons with the Maintenance			4	
				Supervisor/designee will inspe		
	_	our of the facility from 10:20		all interior fire escape stairwel		
	-	n 02/24/23, an extension ladder		throughout the facility weekly	to	
		nclosed stairwell wall in the		ensure they are free of		
		oom 55 on the second floor. In		impediments and projections a		
		ck salt and a wood beam were		part of the facility's Preventive	)	
		closed stairwell at the bottom		Maintenance Program and		
		sed on interview at the time of		document those inspection res		
		e Maintenance Director		as appropriate. If any issues		
	-	ntioned stairwell was used for		discovered, they will be addre		
	storage which could	l interfere with egress.		and resolved immediately. The		
				Maintenance Supervisor/design	gnee	
	These findings were			will review with the Administra	itor	
		he Maintenance Director		the inspection results.		
	during the exit conf	erence.		c. The Administrator will		
				monitor adherence to the		
	3.1-19(b)			Preventative Maintenance		
				schedule and validate the		
		ation and interview, the facility		Preventative Maintenance		
	failed to ensure iten	ns stored in 1 of 3 interior fire		documentation is in place.		
	escape stairways wo	ould not interfere with egress.		4. MONITORING		
	LSC 7.2.2.5.3. state	es enclosed, usable spaces		CORRECTIVE ACTION:		
		es shall be prohibited,		a. The inspection results v	vill	
		irs, unless otherwise permitted		be presented by the Maintena		
		tion 7.2.2.5.3.2 states enclosed,		Supervisor/designee to the		
		be permitted under stairs,		Administrator monthly and the	,	
	_	of the following criteria are		Administrator will present the		
	1 *	U	1	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLETED			ETED	
		155280	B. WING 02/24/2023		2023		
			—				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\		D000 14110D TUE			ENOVER ST		
WATERS OF DILLSBORO-ROSS MANOR, THE			DILLSB	ORO, IN 47018			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	met:				inspection results at the month	nly	
	(1) The space shall	be separated from the stair			Quality Assurance/Performand	ce	
	enclosure by the sa	ame fire resistance as the exit			Improvement (QA/PI) meeting		
	enclosure.				Inspection results and system		
	(2) Entrance to the	enclosed, usable space shall			components will be reviewed I	by	
	not be from within	the stair enclosure. (See also			the QA/PI Committee with		
	7.1.3.2.3.)				subsequent plans of correction	n	
	This deficient prac	tice could affect over 1 staff			developed and implemented a		
		the attic stairwell in the vicinity			deemed necessary to ensure		
	of the second floor	Pantry by Room 51.			compliance is maintained.		
					This plan of correction		
	Findings include:				constitutes our credible		
	_				allegation of compliance witl	h	
	Based on observati	ions with the Maintenance			all regulatory requirements.		
	Director during a t	our of the facility from 10:20			Our date of compliance is		
	a.m. to 2:15 p.m. o	on 02/24/23, a small closet			4/7/23.		
	installed underneat	th the attic stairwell by the					
	Pantry by Room 5	l on the second floor was used					
	for the installation	of an electric water heater					
	location, two boxe	s for sterile supplies, a					
	twenty-gallon was	te can and light bulbs. Based					
	on interview at the	time of the observations, the					
	Maintenance Direc	ctor agreed the aforementioned					
	stairwell was used	for storage under the stairs					
	which could interfe	_					
	These findings wer	re reviewed with the					
	Administrator and	the Maintenance Director					
	during the exit con	ference.					
	3.1-19(b)						
K 0232	NFPA 101						
SS=E	Aisle, Corridor, o	•					
Bldg. 02	Aisle, Corridor or	Ramp Width					
	2012 EXISTING						
	The width of aisles or corridors (clear or unobstructed) serving as exit access shall be						
	at least 4 feet and	d maintained to provide the					
	convenient remov	val of nonambulatory patients					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  02/24/2023			
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD B LENOVER ST	
	OF DILLSBORO-F	ROSS MANOR, THE		SBORO, IN 47018	
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG			TAG	DEFICIENCE	DATE
	19.2.3.4, exceptio	ept as modified by			
	19.2.3.4, exception 19.2.3.5	113 1-3.			
		on and interview, the facility	K 0232	It is the intent of the facility to	04/07/2023
	failed to meet the clear width requirement for 3 of 6		11 0232	ensure to meet the clear width	
	corridors. In CMS'	S&C policy memo 10-18-LSC		requirement for corridors to me	eet
	dated 05/14/10, whi	ich revised S&C-04-41 dated		set standards.	
	08/12/04, corridor wall-mounted computer touch			1. CORRECTIVE ACTIONS	S
	screens shall only be installed in corridors that are			TAKEN:	
		e. This deficient practice could		a. By 4/7/23, the Maintena	
	affect over 40 resid	ents, staff, and visitors.		Supervisor/designee removed	<b>I</b>
				computer touch screens from t	the
	Findings include:			corridor wall outside resident	
				sleeping room 5, room 14 and	
		ons with the Maintenance		room 27 to meet set standards	S.
	_	our of the facility from 10:20		2. ALL OTHERS WITH	
	_	n 02/24/23, a computer touch		POTENTIAL TO BE AFFECTE	
		on the corridor wall outside		a. All residents and all staf	
		oom 5, Room 14, and Room 27.		and visitors have the potential	<b>I</b>
	_	ch screen projected into the ly, 6.0 inches, 7.5 inches and		be affected but none were. By	<b>I</b>
	_	ridor width at each computer		4/7/23, corridors throughout th	<b>I</b>
		on measured 68 inches. Each		facility to ensure no items were being stored improperly and	=
	measurement taken			reducing the width of the corrid	dor
		tor's measuring tape. Based on		and found no other negative	
		e of the observations, the		findings.	
		for agreed the corridor wall		3. MEASURES TO PREVE	NT
		touch screens projected into		REOCCURRENCE:	
	_	g less than six feet in clear and		a. On 3/24/23 the	
	unobstructed width			Administrator inserviced the	
				Maintenance Supervisor/desig	nee
	These findings were			and all other staff on the	
		he Maintenance Director		requirement that no items are	to
	during the exit conf	Perence.		be stored in corridors which we	ould
				reduce the corridor width to me	eet
	3.1-19(b)			set standards.	
				b. Maintenance	
				Supervisor/designee will inspe	ect
				all exit access corridors	
			1	throughout the facility weekly t	o I

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

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STATEMEN					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155280	B. W	ING		02/24/20	023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LENOVER ST	•	
WATERS	OF DILLSBORO-F	ROSS MANOR, THE			ORO, IN 47018		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG		d	DATE
					ensure no items are being sto in the corridors which would	rea	
					reduce the corridor width as a	nart	
					of the facility's Preventive	part	
					Maintenance Program and		
					document those inspection res	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th	I	
					Maintenance Supervisor/desig	gnee	
					will review with the Administra	tor	
					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:	.iu	
					a. The inspection results w		
					be presented by the Maintena Supervisor/designee to the	IICE	
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	<sub>nlv</sub>	
					Quality Assurance/Performand	· .	
					Improvement (QA/PI) meeting		
					Inspection results and system	I	
					components will be reviewed I	by	
					the QA/PI Committee with		
					subsequent plans of correction		
					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.		
I	1		1		Our date of compliance is		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  02/24/2023				
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
K 0271 SS=E Bldg. 02	7.7, provides a leve the provisions of 7 changes in elevating free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 1. Based on observations of fire or other emerged could affect over 20 needing to exit the fire of the facility from 9:35 a exit discharge for the elevators had topso of the paved path of stairwell was marked sign. Based on interest observations, the Marked facility is having our repair and agreed the discharge was not firm fire of the paved path of stairwell was marked sign. Based on interest observations, the Marked facility is having our repair and agreed the discharge was not firm fire of the paved path of stairwell was marked sign. Based on interest observations, the Marked facility is having our repair and agreed the discharge was not firm fire facility in the facility observations with the during a tour of the	rranged in accordance with rel walking surface meeting 7.1.7 with respect to son and shall be maintained as. Additionally, the exit a hard packed all-weather ations and interview, the sure 3 of 14 exit discharges was sained free of all obstructions full instant use in the case of ency. This deficient practice 0 residents, staff and visitors if	K 0271	It is the intent of the facility to ensure exit discharges are continuously maintained free constructions or impediments to instant use in the case of fire conther emergency and to ensure the means of egress in exit discharge to roofs is continuous and safe to meet set standards.  CORRECTIVE ACTIONS TAKEN:  a. On 3/10/23, the Maintenance Supervisor remounted the topsoil piled across the wide of the paved path of egress and repaired the area with concrete meet set standards.  b. On 3/10/23 that were affixed to the exit discharge handrails blocking the exit discharge for the exit door from the Alzheimer's day room and the top of the exterior stairs in exit discharge by room 26 on the second floor to meet set standards.	o full or ee us ss. S ved dth nd e to		

discharge for the stairwell by the new elevators.

C.

On 3/10/23 the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>02</u>		COMPLETED	
		155280	B. W	ING		02/24/2023	
NAME OF D	PROVIDER OR SUPPLIER	,	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
				12803 I	LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSE	3ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(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	DEFICIENCY	DATE	
		were affixed to the exit			Maintenance Supervisor insta		
		blocking the exit discharge for			directional signage to show th		
		he Alzheimer's day room and at			path of egress to the enclosed		
	_	or stairs in the exit discharge second floor. Each of the two			stairwell on the northwest side	e or	
	1 -	ked as a facility exit with an exit			the building to meet set standards.		
		rview at the time of the			2. ALL OTHERS WITH		
	1 -	aintenance Director agreed			POTENTIAL TO BE AFFECTI	ED:	
		C			a. All residents and all sta		
	the aforementioned exit discharges provided an impediment to full instant use in the case of fire or				and visitors have the potential		
	other emergency.				be affected but none were.		
	other emergency.				3. MEASURES TO PREVE	ENT	
	These findings were reviewed with the				REOCCURRENCE:	-141	
	Administrator and the Maintenance Director				a. Maintenance		
	during the exit conf				Supervisor/designee will inspe	ect	
					all exit doors, stairwells exit		
	3.1-19(b)				discharge and paths to public	way	
					to ensure they are readily	,	
	2. Based on observa	ation and interview, the facility			accessible and free of all		
		means of egress in 1 of 2 exit			obstructions or impediments a	as a	
		vas continuous and safe. LSC			part of the facility's Weekly		
	_	exits shall be permitted to			Preventive Maintenance Prog	ram	
		or other sections of the			and document those inspection		
		ning building where all of the			results as appropriate. If any		
	following criteria an				issues are discovered, they w		
	(1) The roof/ceiling	assembly construction has a			addressed and resolved		
	fire resistance rating	g not less than that required			immediately. The Maintenand	ce	
	for the exit enclosur	re.			Supervisor/designee will revie		
	(2) A continuous an	nd safe means of egress from			with the Administrator the		
	the roof is available	s.			inspection results.		
	_	ice could affect over 10			b. The Administrator will		
	residents, staff and	visitors if needing to exit the			monitor adherence to the		
	facility by Room 55	on the second floor.			Preventative Maintenance		
					schedule and validate the		
	Findings include:				Preventative Maintenance		
					documentation is in place.		
		ons with the Maintenance			4. MONITORING		
	Director during a to	our of the facility from 10:20			CORRECTIVE ACTION:		
	a.m. to 2:15 p.m. or	102/24/23, the exit door on the			a. The inspection results v	vill	
	second floor by Roo	om 55 is marked as a facility			be presented by the Maintena	ince	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 02/24/2023		
	PROVIDER OR SUPPLIER S OF DILLSBORO-ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(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)	(X5) COMPLETION DATE		
	exit with an exit sign. The exit discharge for the exit door is on to the roof of the adjoining part of the facility. The path of egress in the exit discharge to the enclosed stairwell is not obvious and is not marked with any signage indicating the path of egress to the enclosed stairwell on the northwest side of the building. Based on interview at the time of the observations, the Maintenance Director agreed the path of egress in the exit discharge to the enclosed stairwell on the second floor is not obvious or marked with signage for the direction of travel.  These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.  3.1-19(b)		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 4/7/23.	nly ce by n		
K 0281 SS=E Bldg. 02	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure egress lighting for 1 of 14 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 10 residents, staff, and visitors in the facility.	K 0281	It is the intent of the facility to ensure egress lighting for exit means of egress is arranged at the failure of any single lighting fixture (bulb) would not leave that area in darkness to meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. On 3/1/23 the Maintena Supervisor/designee replaced	g he S nce		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/24/2023 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE burned out light bulb outside the Findings include: second floor exit door by room 55 and installed egress lighting in Based on observations with the Maintenance the second floor entrance to the Director during a tour of the facility from 10:20 enclosed stairwell outside room 55 a.m. to 2:15 p.m. on 02/24/23, one of two light that had only one light fixture with bulbs in the exit means of egress outside the one light bulb to meet set second-floor exit door by Room 55 was burned standards. out. In addition, the second-floor entrance to the **ALL OTHERS WITH** POTENTIAL TO BE AFFECTED: enclosed stairwell outside Room 55 had only one light fixture with one light bulb. Based on All residents and all staff interview at the time of the observations, the and visitors have the potential to Maintenance Director agreed one of the two light be affected but none were. On bulbs in the aforementioned exit discharge was 3/1/23 the Maintenance burned out and the exit access for the Supervisor/designee inspected all second-floor enclosed stairwell had only one means of egress lights throughout lighting fixture with one light bulb. the facility to ensure exit lighting is working properly and found no These findings were reviewed with the other negative findings. Administrator and the Maintenance Director **MEASURES TO PREVENT** 3. during the exit conference. REOCCURRENCE: On 3/24/23 the 3.1-19(b) Administrator inserviced the Maintenance Supervisor/designee on the requirement that continuity of egress lighting remains for exits to meet set standards. b. Maintenance Supervisor/designee will inspect lighting in all means of egress weekly to ensure lighting is working properly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved

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immediately. The Maintenance Supervisor/designee will review with the Administrator the

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIE	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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
K 0204	NEDA 404			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 who be presented by the Maintenan Supervisor/designee to 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 4/7/23.	nily ce oy
K 0291 SS=F Bldg. 02	duration is provid accordance with 18.2.9.1, 19.2.9.1 1. Based on observ	ng ng of at least 1-1/2-hour ed automatically in 7.9.	K 0291	It is the intent of the facility to ensure battery powered	04/07/2023

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULT		JLTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	02	COMPLETED	
		155280	B. W	ING		02/24/	2023
		-		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			LENOVER ST		
WATERS	S OF DILLSBORO-I	ROSS MANOR, THE			3ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		as maintained in accordance			emergency lighting systems a		
		7.9. LSC 7.9.2.6 states battery			maintained in accordance with		
		y lights shall use only reliable			LSC Section 7.9 and to docur		
		ble batteries provided with			monthly and annual testing fo	r all	
		or maintaining them in properly			battery backup lights in		
	_	Batteries used in such lights			accordance with LSC 7.9 to m	neet	
		proved for their intended use			set standards.		
		vith NFPA 70, National Electric			1.CORRECTIVE ACTIONS		
		nt practice could affect all			TAKEN:		
	residents, staff and	visitors.			1.On 3/1/23 the Mainten		
					Supervisor/designee replaced	I the	
	Findings include:				light in the battery operated		
					lighting system that is affixed	to	
		ons with the Maintenance			the wall above the facility's		
	_	our of the facility from 10:20			emergency generator installed		
	_	n 02/24/23, the battery-operated			the basement and documente	ed	
		ixed to the wall above the			the results on the		
		y generator installed in the			Battery-Operated Emergency		
		illuminate when its respective			Lights and signs Test Log to r	neet	
	_	hed multiple times. Based on			set standards.		
		ne of the observations, the			2.On 3/1/23 the Mainten		
		tor agreed the aforementioned			Supervisor/designee conducte		
		nergency lighting system failed			the monthly and annual batter	-	
		its respective test button was			operated light testing on all se		
	pushed multiple tin	nes.			battery operated lighting syste		
					and documented the results of		
	1	re reviewed with the			the Battery-Operated Emerge	-	
		the Maintenance Director			Lights and signs Test Log to r	neet	
	during the exit conf	terence.			set standards.		
					2.ALL OTHERS WITH		
	3.1-19(b)				POTENTIAL TO BE AFFECT		
					1.All residents and all sta		
		review, observation, and			and visitors have the potentia	l to	
		ity failed to document monthly			be affected but none were.	_	
	_	for all battery backup lights in			3.MEASURES TO PREVEN	Т	
		SC 7.9. Section 7.9.3.1.1 states			REOCCURRENCE:		
		cy lighting systems shall be			1.On 3/24/23 the		
	permitted to be con				Administrator inserviced the		
		ng shall be conducted monthly,			Maintenance Supervisor/design	-	
	with a minimum of 3 weeks and a maximum of 5				on the requirement to provide	and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>		COMPLETED	
		155280	B. W	ING		02/24/2023	
		<u>l</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE			BORO, IN 47018		
	ı		1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	N. T
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		JΝ
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		s, for not less than 30			maintain emergency lighting a		
		otherwise permitted by			conduct the monthly and annu		
	7.9.3.1.1(2).	-1-11 1			testing and document the resu	IITS	
		shall be permitted to be			to meet set standards.		
	I	days with the approval of the			2.Maintenance	4-	
	authority having jun				Supervisor/designee will ensu		
	` '	ng shall be conducted annually			provide and maintain emerger	· .	
		1/2 hours if the emergency			lighting and conduct the mont	· .	
	lighting system is b				and annual testing as a part o		
		lighting equipment shall be			facility's Preventive Maintenar		
		r the tests required by			Program and document those		
	7.9.3.1.1(1) and (3)				tests on the Battery-Operated		
	1 1	of visual inspections and tests			Emergency Lights and signs		
		owner for inspection by the			Log and will maintain emerge		
	authority having ju				lighting to meet set standards		
	_	ice could affect all residents,			any issues are discovered, the	•	
	staff, and visitors.				will be addressed and resolve		
	E' 1' ' 1 1				immediately. The Maintenand		
	Findings include:				Supervisor/designee will revie	w	
	D1	"ID-44 O4-1 E			with the Administrator the		
		"Battery-Operated Emergency			inspection results.		
		est Log" documentation with			3.The Administrator will		
		rector during record review			monitor adherence to the		
		12:45 p.m. on 02/23/23, monthly			Preventative Maintenance		
		operated light testing he most recent twelve-month			schedule and validate the		
		d a total of four battery			Preventative Maintenance		
		stems which were tested.			documentation is in place.	VE	
	'	at the time of record review,			4.MONITORING CORRECT ACTION:	VE	
		rector stated he started				adill	
		ity within the last year and was			1.The inspection results		
	_	ity had more than four battery			be presented by the Maintena	IICE	
		estems or not. Based on			Supervisor/designee to the Administrator monthly and the		
	'	ne Maintenance Director			Administrator monthly and the Administrator will present the		
		facility from 10:20 a.m. to 2:15			•	alv.	
		total of seven battery operated			inspection results at the month	•	
	_	ere noted in the facility which			Quality Assurance/Performan Improvement (QA/PI) meeting		
	~ ~ .	ions in the Therapy Room area			` ` '		
	_				Inspection results and system		
		ach battery-operated lighting when its respective test button			the QA/PI Committee with	ру	
1	i system illuminated	when his respective test putton	1		LIDE CIA/PLC.OMMITTEE WITH	ı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 02/24/2023	
	ROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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)	DATE
K 0293	light location install location in the baser These findings were	e reviewed with the he Maintenance Director		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 4/7/23.	as
SS=E Bldg. 02	Exit Signage Exit Signage 2012 EXISTING Exit and directional accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of eased on observation failed to ensure 1 of facility in the second were not mistaken a states any door, passed neither an exit nor a located or arranged mistaken for an exit that reads as follows sign shall have the whigh, with a stroke word EXIT below this an approved exist practice could affect	less than 30 occupants exit travel is obvious.) on and interview, the facility of 1 doors to the outside of the d floor Activities/Dining Room as a facility exit. LSC 7.10.8.3.1 stage, or stairway that is away of exit access and that is so that it is likely to be shall be identified by a sign so that it is likely to be shall be identified by a sign so NO EXIT. The NO EXIT word NO in letters 2 inches width of 3/8ths inch, and the the word NO, unless such sign ing sign. This deficient to over 10 residents, staff, and try of the door in the second	K 0293	It is the intent of the facility to ensure doors to the outside of facility in the second floor Activities / Dining Room are n mistaken as a facility exit to m set standards.  1. CORRECTIVE ACTION TAKEN:  a. By 4/7/23 the Maintena Supervisor/designee will have installed a No Exit Sign at the door to the outside of the build in the second floor Activities/Dining Room to mee standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTI	ot neet S nce ding

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER)  155280		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COMP	ESURVEY LETED 1/2023	
	PROVIDER OR SUPPLIE S OF DILLSBORO-	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COI LENOVER ST BORO, IN 47018	)	
(X4) ID PREFIX TAG	(EACH DEFICIEI REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE
	Director during a ta.m. to 2:15 p.m. of outside of the build Activities/Dining I EXIT sign. Based observations, the Moor is not a facility with a NO EXIT sign. This finding was re-	ions with the Maintenance our of the facility from 10:20 in 02/24/23, the door to the ding in the second floor Room was not posted with a NO on interview at the time of the Maintenance Director stated the y exit and should be equipped ign.  Eviewed with the Administrator ce Director during the exit		a. All residents and a and visitors have the pot be affected but none were 3. MEASURES TO PREOCCURRENCE: a. On 3/24/23 the Administrator inserviced Maintenance Supervisor on the requirement to en provide and maintain exidirectional exit signs to neath the exits the set standards. b. Maintenance Supervisor/designee will monthly check of all emerexit signs and document inspection results on the Emergency Lights & Signal Log as a part of the facilial Preventive Maintenance Program. If any issues discovered, they will be a and resolved immediated Maintenance Supervisor will review with the Admit the inspection results. c. The Administrator monitor adherence to the Preventative Maintenance Schedule and validate the Preventative Maintenance All Monitoring Corrective Action: a. The inspection results and the inspection results and the inspection results and the inspection is in placed.  MONITORING CORRECTIVE ACTION: a. The inspection results and the inspectio	the //designee sure to t and nark exit to meet  conduct a ergency those ns Test sty's are addressed y. The //designee nistrator  will exe exe exe exe exe exe exe exe end the exe exe exe exe exe exe exe exe exe e	

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155280	A. BUILDING  B. WING	02	COMPLETED 02/24/2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 Լ	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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)	DATE
K 0244	NEDA 404			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 4/7/23.	og Dy n s
K 0311 SS=E Bldg. 02	openings between construction havin at least 1 hour. An accordance with 8 19.3.1.1 through 1 If all vertical openi	r shafts, light and chutes, and other vertical floors are enclosed with g a fire resistance rating of atrium may be used in .6. 9.3.1.6 ngs are properly enclosed providing at least a 2-hour			
	1. Based on observa failed to maintain postairwells. LSC 19. shall be enclosed or Section 8.6. LSC 8. separates stories in a constructed as a sme	tion and interview, the facility rotection of 3 of 4 interior 3.1 requires vertical openings protected in accordance with 6.1 requires every floor that a building shall be oke barrier. LSC 8.6.5 states losures of exits. LSC 7.1.3.2.1	K 0311	It is the intent of the facility to ensure to maintain protection of interior stairwells and to ensure the protection of the soiled line chutes and the two story convenience stairs are in accordance with 19.3.1 and to ensure freight elevators are	e en

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ENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	02	COMPLETED	
155280 B. WING		<u> </u>	02/24/2023		
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>		ADDRESS, CITY, STATE, ZIP COD	
WATERS OF BUILDING BOOK MANOR THE			LENOVER ST		
WATERS	OF DILLSBURU-F	ROSS MANOR, THE	DILLSE	3ORO, IN 47018	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	states the separation	n shall have a minimum 1-hr		enclosed with at least 1 hour	
	fire resistance rating	g where the exit connects three		resistance rating to meet set	
	stories or less. Fire	doors assemblies are in		standards.	
	accordance with NI	FPA 80, Standard for Fire		1. CORRECTIVE ACTION	S
	Doors and Other O	pening Protectives. NFPA 80,		TAKEN:	
	Section 4.8.4.1 state	es the clearance under to		a. The facility will have a	
	bottom of a door sh	all be a maximum of 3/4th's		passing FSES survey	
	inch. This deficient	t practice could affect over 20		conducted. (stairwell door on	the
	residents, staff, and	visitors.		first floor by room 7 and on the	
				second floor by room 37)	
	Findings include:			b. The facility will have a	n
				FSES survey conducted to	
	Based on observation	ons with the Maintenance		include all 5 smoke zones. (c	one
	Director during a to	our of the facility from 10:20		layer of 5/8" thick drywall, whi	
	a.m. to 2:15 p.m. or	n 02/24/23, the following was		was hung vertically, was used	
	noted:	,		cover the spiral staircase ope	
	a. the stairwell door	on the first floor by Room 7		at the bottom of the staircase)	-
		loor by Room 37 were each		c. By 4/7/23 the Maintena	
		fire resistance rating label.		Supervisor/designee will have	
	Based on interview			a 1 hour fire-resistant materia	
		faintenance Director agreed		seal the one quarter inch gap	
		rwell doors did not have a fire		noted between the top of the	door
		pel affixed to the door.		frame and the wall for the stai	
	_	n's inch thick drywall, which		to the attic to meet set	
		, was used to cover the spiral		standards.	
		the bottom of the staircase		d. By 4/7/23 the Maintena	nce
		ose the staircase with a		Supervisor/designee will have	
		re resistance rating. The one		repaired the stairwell door to t	
		the bottom of the staircase was		closet by the attic stairwell do	
		wall by the second floor		so it self closes and latches fu	
	Janitor's closet by the			into the frame to meet set	····,
		h gap was noted in between		standards.	
	-	frame and the wall for the		e. By 4/7/23 the Maintena	nce
	stairwell door to the			Supervisor/designee will have	
		r to the closet by the attic		repaired the latching mechani	
		equipped with a self-closing		on the soiled linen chute in the	
		om of the door kept getting			
		on the floor and would not		electrical room by Room 39 o second floor and on the first fl	
	_	into the door frame when			UUI
				by Room 5 to meet set	
	tested to close mult	ipie umes.	1	standards.	l

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>			COMPLETED	
		155280	B. W	B. WING 02/24/2023			/2023	
		<u> </u>		CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
\\/ATED(		DOCC MANOR THE			LENOVER ST			
WATERS	S OF DILLSBURU-	ROSS MANOR, THE		DILLOB	BORO, IN 47018			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Based on interview	at the time of the			f. The facility is requesting	ga		
	observations, the M	Saintenance Director agreed			waiver for this and will have a	n		
	the stairwell doors	were not equipped with fire			FSES survey conducted.			
	resistance rating lal	bel, the bottom of the spiral			(Stairwell wall on the first story	y by		
	staircase in the attic	was not enclosed with 1-hour			room 17 and the second floor	by		
	fire resistance ratin	g and the two stairwell doors			room 26 only extends to the			
	would not resist the	e passage of smoke.			underside of the suspended			
					acoustical tile ceiling system)			
	These findings wer	e reviewed with the			g. By 4/7/23 the Maintena	nce		
	Administrator and	the Maintenance Director			Supervisor/designee will have	)		
	during the exit con	ference.			repaired the access door to th	ie		
					freight elevator shaft to ensure	e it		
	3.1-19(b)				self closes and has a positive			
					latching mechanism to meet s	et		
	2. Based on observ	ation and interview, the facility			standards.			
	failed to ensure the	protection of the soiled linen			h. By 4/7/23 the Maintena	nce		
	chutes and the two-	story convenience stairs was			Supervisor/designee will have	used		
	in accordance with	19.3.1. LSC 19.3.1.1 states			a 1 hour fire-resistant materia	l to		
	where enclosure is	provided, the construction			seal the penetration from the			
	shall have not less	than a 1-hour fire resistance			bundle of TV cables that			
	rating. LSC 8.3.4.2	2 states the fire protection rating			penetrated the wall of the freig	ght		
	for opening protect	ives shall be in accordance			elevator shaft above the shaft	· •		
	with Table 8.3.4.2	except as otherwise permitted in			access door to meet set			
	8.3.4.3 or 8.3.4.4. T	Table 8.3.4.2 requires fire door			standards.			
	assemblies in vertice	cal shafts, including stairways,			i. By 4/7/23 the Maintena	ınce		
	to have a 1-hour fir	re resistance rating. LSC 8.3.4.3			Supervisor/designee will have	used		
	states existing fire	door assemblies having a			a 1 hour fire-resistant materia	l to		
	minimum ¾-hour f	ire protection rating shall be			seal the annular space			
	permitted to contin	ue to be used in vertical			surrounding horizontal sprinkle	er		
	openings and exit e	enclosures in lieu of the			piping which penetrated the fr	eight		
	minimum 1-hour fi	re protection rating required in			elevator shaft to meet set			
	Table 8.3.4.2. This	deficient practice could affect			standards.			
	over 20 residents, s	taff, and visitors.			2. ALL OTHERS WITH			
					POTENTIAL TO BE AFFECTI	ED:		
	Findings include:				a. All residents and all sta	ff		
					and visitors have the potential	to		
	Based on observati	ons with the Maintenance			be affected but none were.			
	Director during a to	our of the facility from 10:20			3. MEASURES TO PREVE	ENT		
	a.m. to 2:15 p.m. o	n 02/24/23, the soiled linen chute			REOCCURRENCE:			
	in the electrical roo	om by Room 39 on the second			a. On 3/24/23 the			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY  COMPLETED  02/24/2023	
			CTREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	8		LENOVER ST	
WATERS	OF DILLSBORO-F	ROSS MANOR, THE		BORO, IN 47018	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN 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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		st floor by Room 5 contains		Administrator inserviced the	
	*	construction of the shaft. The		Maintenance Supervisor/design	-
		chute on the first floor by the		on the requirement that all sm	
	•	alarm control panel is 1-hour fire		barrier doors must self close	
	resistance rated and			latch and have fire resistance	
		and a latching mechanism, but		rating labels and/or have an F	
		nism did not latch into the door		completed, all smoke barrier	
		to self-close and latch into the		are free of penetrations, and	all
		hen tested to close multiple		chutes, shafts, and stairs are	
		ould only latch into the door		constructed with fire-resistant	
		andle was manually twisted		materials to meet set standar	ds.
	_	nute door. In addition, the		b. Maintenance	,
	stairwell wall on the first story by Room 17 and on			Supervisor/designee will inspe	
		Room 26 only extends to the		monthly throughout the facility	l l
		spended acoustical tile ceiling		smoke barrier doors are free	
		the tile in the ceiling system op plate and edge of the		penetrations, have fire resista	ince
	-	assembly. The existing		rating labels and self-closing	tod
		assembly. The existing nce stair opening does not		devices and/or FSES complete	
		ed by a minimum one-hour		inspect all smoke barrier walls	5 101
		ion. Based on interview at the		penetrations, and ensure all chutes, shafts, and stairs are	
		tion, the Maintenance Director		constructed with fire-resistant	
		nen chute and the two-story		materials as a part of the facil	
		did not appear to be complete		Preventive Maintenance Prog	-
	with fire-rated asser			and document those inspection	
	, , , , , , , , , , , , , , , , , , ,			results as appropriate. If any	
	These findings were	e reviewed with the		issues are discovered, they w	
		he Maintenance Director		addressed and resolved	
	during the exit conf			immediately. The Maintenand	ce
	8			Supervisor/designee will revie	
	3.1-19(b)			with the Administrator the	
				inspection results.	
	3. Based on observa	ation and interview, the facility		c. The Administrator will	
	failed to ensure 1 of	f 1 freight elevators was		monitor adherence to the	
	enclosed with at lea	st 1-hour resistance rating.		Preventative Maintenance	
	This deficient pract	ice could affect over two staff		schedule and validate the	
	and visitors in the a	ttic.		Preventative Maintenance	
				documentation is in place.	
	Findings include:			4. MONITORING	
				CORRECTIVE ACTION:	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LEG IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
TAG	Based on observation Director during a total a.m. to 2:15 p.m. or noted in the attic:  a. the access door to wood and had one I drywall affixed to the door. In addition, the self-closing or autorical equipped with a post latch the door into the b. a bundle of cable of the freight elevate access door and the firestopped.  c. the annular space sprinkler piping where elevator shaft had be the caulk had dried Based on interview observations, the Methotopof the freight at least 1-hour resist These findings were Administrator and the during the exit confidence.	TV cables penetrated the wall or shaft above the shaft penetration was not surrounding horizontal ich penetrated the freight een filled with fire caulk, but up exposing the shaft. at the time of the aintenance Director agreed t elevator shaft enclosed with tance rating.	TAG	a. The inspection results to 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 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 4/7/23.	hly ice g. by in
K 0321 SS=E Bldg. 02	barrier having 1-he (with 3/4 hour fire automatic fire exti accordance with 8 approved automat				

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` ′		` <i>′</i>	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 02 COMPLETED  D. WING 02/24/2023		
		155280	B. WING			02/24/2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	128	EET ADDRESS, CITY 803 LENOVER S LSBORO, IN 47	ST	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVII	DER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	X (EACH CORI	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC		DEFICIENCY)	DATE
	partitions and doo	s by smoke resisting ors in accordance with 8.4.				
	Doors shall be sel	_				
	_	and permitted to have				
		applied protective plates that				
		inches from the bottom of				
	the door.	and many langtions of				
		and zone locations of				
	REMARKS.	that are deficient in				
	19.3.2.1, 19.3.5.9					
	19.0.2.1, 19.0.0.9					
	Area	Automatic Sprinkler				
	Separation					
	a. Boiler and Fuel	-Fired Heater Rooms				
	b. Laundries (larg	er than 100 square feet)				
	c. Repair, Mainter	nance, and Paint Shops				
	d. Soiled Linen Ro	ooms (exceeding 64				
	gallons)					
	e. Trash Collection					
	(exceeding 64 gal	· ·				
		orage Rooms/Spaces				
	(over 50 square fe	•				
	`	classified as Severe				
	Hazard - see K32	2) on and interview, the facility	17 0221	14 :- 41 :4		04/07/2022
		f over 10 hazardous areas such	K 0321		ent of the facility to zardous areas such	04/07/2023
		trash collection rooms			zardous areas sucn leater rooms are	as
		ns size were separated from			from other spaces I	hv
		•			istant partitions and	•
	other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic				neet set standards.	'
		ce with 7.2.1.8. This deficient			RECTIVE ACTION	s
		et over 20 residents, staff, and		TAKEN:		· <del>-</del>
	visitors.	, ,			23 the Maintenance	.
				1	r/designee will have	
	Findings include:				two inch hole with	
				one hour f	ire resistant materia	ıl by
	Based on observation	ons with the Maintenance			Ross manor to me	•
	Director during a to	our of the facility from 10:20		set standa	rds. ALL OTHERS	
	a.m. to 2:15 p.m. on 02/24/23, a one quarter inch in			WITH POT	ENTIAL TO BE	

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

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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
IAU	diameter hole was refor the corridor doo the Shower Room be In addition, the secontained soiled lin gallons in size. The not equipped with a interview at the tim Maintenance Direct hazardous areas we spaces by smoke resulting the second spaces.	to the soiled utility room by ty Room 10 on the first floor. and floor Shower room ten and trash carts exceed 64 to corridor door to the room was self-closing device. Based on the of the observations, the or agreed the aforementioned tre not separated from other sistant partitions and doors.  The reviewed with the the Maintenance Director		AFFECTED:  a. All residents and all staff and visitors have the potential to be affected but none were. By 4 the Maintenance Supervisor/designee will have inspected all hazardous areas found no other negative finding.  MEASURES TO PREVINGE TO PRE	nd pe ////23 e s and ggs. ENT tor s n ant eet ect / to re by d s ram on / ill be

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PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155280	B. W	ING		02/24/	/2023
	PROVIDER OR SUPPLIE		•	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST	<u> </u>	
WATERS	S OF DILLSBORO-	ROSS MANOR, THE		DILLSE	BORO, IN 47018		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY 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
					documentation is in place.  4.MONITORING CORRECTIV ACTION:  a. The inspection results will be presented by the Maintenance 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	hly ce J. by	
K 0345 SS=C Bldg. 02	in accordance wir complying with the National Electric National Fire Alan Records of system and testing are re 9.6.1.3, 9.6.1.5, N 1. Based on record	m - Testing and m is tested and maintained th an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance	K 0	345	<ul> <li>- It is the intent of the facility tensure fire alarm system initia</li> </ul>		04/07/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155280		(X2) MULTIPLE C A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 02/24/2023	
	PROVIDER OR SUPPLIER S OF DILLSBORO-F	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DPRIATE DATE
	system initiating de tested in accordance inspection and testi LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nat 72, National Fire A NFPA 72, 2010 Eds smoke detectors shat semiannually. NFF at 15(h) states smol functionally tested 14.3.1 at 9(f) states inspected semiannus states heat detector accordance with the Initial/Reacceptance the time of installat the requirements of detectors. Section fixed-temperature, the better than 14.4.5.5.4. Two or on each initiating cidetectors shall be tested in accordance of the time of installating cidetectors shall be tested in accordance than 14.4.5.5.4.	existing shall be performed in eschedules in Table 14.4.5. testing shall be performed in Table 14.4.5. states restorable spot-type heat detectors shall apply to heat 14.4.5.5.1 through more detectors shall be tested ircuit annually. Different ested each year. NFPA 72,		devices are inspected and in accordance with the sch for inspection and testing frequencies in NFPA 72 arensure the fire alarm syste accurate time and date infi in accordance with require of NFPA 101-2012 edition. Sections 19.3.4 and 9.6 ar NFPA 72 – 2010 edition, Sections 19.3.4 and 9.6 ar NFPA 72 – 2010 editi	tested nedules  and to sem has cormation sements sections  described fire will all heat accility section and secti
	2010 Edition, Table fixed-temperature, detectors functional mechanically and e shall be measured a acceptance test shall shall be kept by the which detectors have years, each detector deficient practice of and visitors.  Findings include:	e 14.4.2.2 at 14(d)(2) states nonrestorable line type heat		Dillsboro building to meet standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFE a. All residents and all and visitors have the poter be affected but none were 3. MEASURES TO PR REOCCURRENCE: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/d on the requirement that he detectors must be inspected tested and the fire alarm of panel must show correct times.	CTED: staff ntial to . EVENT  ne esignee eat ed and ontrol

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPL	
		155280	B. W	ING		02/24/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSBORO, IN 47018			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	or's "Heat & Carbon Monoxide			day to meet set standards.		
	Detectors" section of	of the "Fire Alarm System			b. Maintenance		
		lated 08/04/22 and 02/17/23 for			Supervisor/designee will ensu	re	
	the Waters of Dillsb	ooro building with the			inspections of heat detectors	are	
	Maintenance Direct	for during record review from			conducted and the control par	nel	
	10:00 a.m. to 12:45	p.m. on 02/23/23, no heat			shows correct time of day as a	а	
		d as being installed in the			part of the facility's Monthly		
		detectors were listed as			Preventive Maintenance Prog	ram	
	inspected or tested	within the most recent			and document those inspection	n	
	twelve-month perio	d. Based on interview at the			results as appropriate. If any		
	time of record revie	w, the Maintenance Director			issues are discovered, they w	ill be	
	stated additional fire	e alarm inspection			addressed and resolved		
	documentation for t	he most recent twelve-month			immediately. The Maintenand	e	
	period was not avai	lable for review and stated the			Supervisor/designee will revie	W	
	facility has two elev	vator machine rooms. Based			with the Administrator the		
	on observations wit	h the Maintenance Director			inspection results.		
	during a tour of the	facility from 10:20 a.m. to 12:45			c. The Administrator will		
	p.m. on 02/24/23, o	ne heat detector was installed			monitor adherence to the		
	in the elevator mach	nine room on the first floor by			Preventative Maintenance		
	Room 7. One heat	detector was also installed in			schedule and validate the		
	the basement elevat	or machine room. Based on			Preventative Maintenance		
	interview at the tim	e of record review and of the			documentation is in place.		
	observations, the M	aintenance Director agreed it			4. MONITORING		
	could not be ensure	d the aforementioned fire			CORRECTIVE ACTION:		
	alarm system inspec	ction documentation included			a. The inspection results v	vill	
	elevator machine ro	oom initiating device inspection			be presented by the Maintena	nce	
	and testing within the	he most recent twelve-month			Supervisor/designee to the		
	period.				Administrator monthly and the	!	
					Administrator will present the		
	These findings were	e reviewed with the			inspection results at the montl	nly	
	Administrator and t	he Maintenance Director			Quality Assurance/Performan	ce	
	during the exit conf	erence.			Improvement (QA/PI) meeting	J.	
					Inspection results and system		
	3.1-19(b)				components will be reviewed	by	
					the QA/PI Committee with		
	2. Based on observa	ation and interview, the facility			subsequent plans of correction	n	
	failed to maintain the fire alarm system to assure				developed and implemented a		
	that it had accurate	time and date information in			deemed necessary to ensure		
	accordance with the	e requirements of NFPA 101-			compliance is maintained.		
		ons 19.3.4 and 9.6 and NFPA 72			This plan of correction		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLE	TED
		155280	B. W	NG		02/24/2	2023
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LENOVER ST		
WATERS OF DILLSBORO-ROSS MANOR, THE							
WATERS	OF DILLSBURU-F	RUSS MANUR, THE		DILLOB	ORO, IN 47018		
(X4) ID	SUMMARY S	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
	- 2010 edition, Secti	ions 14.1, 14.1.1. This deficient			constitutes our credible		
	practice could affect	t all residents, staff, and			allegation of compliance with	n	
	visitors.				all regulatory requirements.		
					Our date of compliance is		
	Findings include:				4/7/23.		
	Based on observation	ons with the Maintenance					
	Director during a to	ur of the facility from 10:20					
	a.m. to 2:15 p.m. on	02/24/23, the time of day for					
	the main fire alarm	control panel in the Waters of					
	Dillsboro building v	vas incorrect. The display read					
	_	:05 p.m. at 1:10 p.m. Based on					
		e of the observations, the					
		or agreed the main fire alarm					
	-	e Waters of Dillsboro building					
	did not display the c	correct time of day.					
	These findings were	reviewed with the					
	_	he Maintenance Director					
	during the exit confe						
	during the exit com	erenee.					
	3.1-19(b)						
K 0351	NFPA 101						l
SS=E	Sprinkler System -	· Installation					
Bldg. 02	Spinkler System -						
	2012 EXISTING						
	Nursing homes, ar	nd hospitals where required					
	by construction type	oe, are protected					
	throughout by an a	approved automatic					
		n accordance with NFPA					
	13, Standard for th	ne Installation of Sprinkler					
	Systems.						
	• •	nstruction, alternative					
		es are permitted to be					
	•	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.						
		klers are not required in					
	ciotnes closets of	patient sleeping rooms					

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Event ID:

Z6R521

Facility ID: 000178

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/24/2023 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) K 0351 04/07/2023 Based on observation and interview, the facility It is the intent of the facility to failed to ensure the spray pattern for sprinkler ensure the spray pattern for heads were not obstructed in 2 of over 2 second sprinkler heads is not obstructed floor closets in accordance with LSC 19.3.5.1. in 2 of over 2 second floor closets NFPA 13, 2010 edition, Section 8.5.5.1 states in accordance with LSC 19.3.5.1 sprinklers shall be located so as to minimize to meet set standards. obstructions to discharge as defined in Section 1. **CORRECTIVE ACTIONS** 8.5.5.2 and Section 8.5.5.3 or additional sprinklers TAKEN: shall be provided to ensure adequate coverage of By 4/7/23 the Maintenance the hazard. Sections 8.5.5.2 and 8.5.5.3 do not Supervisor/designee will have permit continuous or noncontinuous obstructions removed the shelf storage within less than or equal to 18 inches below the sprinkler 10 inches of the ceiling mounted deflector or in a horizontal plane more than 18 sprinkler that was noted in the inches below the sprinkler deflector that prevent closet with the double doors the spray pattern from fully developing. This outside the Activity Directors office deficient practice could affect over 20 residents, by room 53 on the second floor staff, and visitors in the vicinity of the second and he repaired the back wall of floor Pantry. the closet to have 18" clearance on the second floor by the Findings include: stairwell to meet set standards. 2. **ALL OTHERS WITH** Based on observations with the Maintenance POTENTIAL TO BE AFFECTED: Director during a tour of the facility from 10:20 All residents and all staff a.m. to 2:15 p.m. on 02/24/23, shelf storage within and visitors have the potential to 10 inches of the ceiling mounted sprinkler was be affected but none were. noted in the closet with the double doors outside 3. **MEASURES TO PREVENT** the Activity Director's Office by Room 53 on the REOCCURRENCE: second floor. In addition, the back wall of the On 3/24/23 the closet which adjoins the Pantry on the second Administrator inserviced the floor by the stairwell on the second floor does not Maintenance Supervisor/designee extend to the ceiling and blocks the spray pattern on the requirement that the spray of the ceiling mounted sprinkler in the Pantry. A pattern for sprinklers heads must sprinkler is not installed in the closet. Based on not be obstructed to meet set

Z6R521

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	02	COMPLE	
		155280	B. WI	NG		02/24/2	2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE.	DATE
	interview at the tim	e of observation, the			standards.		
	Maintenance Direct	or agreed the aforementioned			b. A Certified sprinkler		
	two areas have obst	ructions to sprinkler			contractor/Maintenance		
	coverage.				Supervisor/designee will inspe	ect	
					all sprinkler heads monthly to		
	These findings were				ensure the spray pattern is no	t	
		he Maintenance Director			obstructed as a part of the		
	during the exit conf	erence.			facility's monthly Preventive		
					Maintenance Program and		
	3.1-19(b)				document those inspection re-		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra	itor	
					the inspection results.		
					c. The Administrator will		
					monitor adherence to the Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:		
					a. The inspection results v	<sub>vill</sub>	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the	,	
					Administrator will present the		
					inspection results at the montl	nly	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting	j.	
					Inspection results and system		
					components will be reviewed	by	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	as	
					deemed necessary to ensure		
					compliance is maintained.		
	l				This plan of correction		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>02</u>	COMPL	ETED
		155280	B. W	NG		02/24/	2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDENCE N. AN OF CORD		PROVIDENCE BLANCE 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 APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
					constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.	1	
K 0353 SS=F Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record r interview; the facilit sprinkler systems in LSC 9.7.5 requires a inspected, tested, an with NFPA 25, Start Testing, and Mainte Protection Systems. Section 4.1.4.1 state designated represent deficiencies or impat the inspection, test a	supply source  RKS information on non-required or partial r system.	K 0	353	It is the intent of the facility to ensure to maintain automatic sprinkler systems in accordance with NFPA 25 to meet set standards.  1.CORRECTIVE ACTIONS TAKEN: 1.By 4/7/23 a Certified Sprinkler Contractor/Maintenar Supervisor/designee will have repaired the accelerator and the tamper switch for the dry sprinkler contractor with the dry sprinkler contractor and the supervisor witch for the dry sprinkler contractor with the dry sprinkler contractor and the supervisor witch for the dry sprinkler contractor with the supervisor witch supervisor wi	nce	04/07/2023

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Facility ID: 000178

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED	
		155280	B. W	ING		02/24/	2023	
				·				
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD			
\A/A TED	05 011 00000	DOOD MANOR THE			LENOVER ST			
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSBORO, IN 47018				
(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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	performed by qualit	fied maintenance personnel or			system in Ross Manor to mee	et		
	a qualified contract	or. NFPA 25, 4.3.1 requires			set standards.			
	records shall be made for all inspections, tests,				2.ALL OTHERS WITH			
	and maintenance of	the system components and			POTENTIAL TO BE AFFECT	ED:		
	shall be made availa	able to the authority having			1.All residents and all sta	aff		
	jurisdiction upon re	quest. This deficient practice			and visitors have the potential	l to		
	could affect all resid	dents, staff, and visitors in the			be affected but none were.			
	Waters of Dillsboro	).			3.MEASURES TO PREVEN	Т		
					REOCCURRENCE:			
	Findings include:				1.On 3/24/23 the			
					Administrator inserviced the			
	Based on review of	the sprinkler system			Maintenance Supervisor/desi	gnee		
	inspection contracto	or's "Work Performed"			on the requirement that the			
	documentation date	ed 11/22/22 with the			sprinkler system must be prop	erly		
	Maintenance Direct	tor during record review from			maintained to meet set standa	ards.		
	10:00 a.m. to 12:45	p.m. on 02/23/23, the accelerator			2.Maintenance			
	for the dry sprinkle	r system in the Waters of			Supervisor/designee will ensu	ire		
	Dillsboro building i	needs to be replaced. The			the sprinkler systems are			
	contractor's 11/22/2	22 report stated "send quote to			maintained as a part of the			
	_	It would reset but never built			facility's monthly Preventive			
	_	n interview at the time of			Maintenance Program and			
	· ·	Maintenance Director stated			document those inspection re	sults		
	sprinkler system rep	·			as appropriate. If any issues			
		the Waters of Dillsboro			discovered, they will be addre	ssed		
		11/22/22 was not available for			and resolved immediately. Th			
		observations with the			Maintenance Supervisor/desig	-		
		tor during a tour of the facility			will review with the Administra	ator		
		2:15 p.m. on 02/24/23, the			the inspection results.			
		has supervised wet and dry			3.The Administrator will			
	sprinkler systems.				monitor adherence to the			
					Preventative Maintenance			
	These findings were				schedule and validate the			
	Administrator and the Maintenance Director				Preventative Maintenance			
	during the exit conference.				documentation is in place.			
					4.MONITORING CORRECT	IVE		
	3.1-19(b)				ACTION:			
					1.The inspection results			
	2. Based on observation, and interview, the				be presented by the Maintena	ince		
		sure 1 of 4 sprinkler heads in			Supervisor/designee to the			
	Room 74 covered w	vith dust were replaced or			Administrator monthly and the	;		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280			UILDING	02	COMPL 02/24/	ETED	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD  12803 LENOVER ST  DILLSBORO, IN 47018				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	cleaned in accordant Standard for the Instandard fo	the with NFPA 25. NFPA 25, spection, Testing, and ter-Based Fire Protection ion, Section 5.2.1.1.1 states show signs of leakage; shall, foreign materials, paint, and and shall be installed in the fe.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be the glass bulb heat responsive sprinklers that are loaded with to clean sprinklers with ya vacuum provided that the touch the sprinkler. ice could affect over 10 visitors in the vicinity of the facility from 10:20 to 102/24/23, the ceiling mounted est the corridor door in Room the spider webs and dust. Based time of the observations, the corragreed the aforementioned was covered with spider webs			Administrator will present the inspection results at the month Quality Assurance/Performand 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 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 4/7/23.	ce	

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Event ID:

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Facility ID: 000178

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  02			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155280	B. W		02	02/24/	
		100200	Б. ,,,			02/2-1	2020
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LENOVER ST		
WATERS	OF DILLSBORO-F	ROSS MANOR, THE		DILLSBORO, IN 47018			
(X4) ID	SUMMARY S	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		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	during the exit confe	he Maintenance Director					
	during the exit confe	erence.					
	3.1-19(b)						
K 0355	NFPA 101						
SS=E	Portable Fire Extin	nguishers					
Bldg. 02	Portable Fire Extir						
	Portable fire exting	guishers are selected,					
	•	d, and maintained in					
		IFPA 10, Standard for					
	Portable Fire Extin	•					
	18.3.5.12, 19.3.5.1	•					0.4/0.7/0.000
		ation and interview, the facility	K 0	355	It is the intent of the facility to ensure portable fire extinguishers		04/07/2023
		26 portable fire extinguishers cordance with NFPA 10.					
		for Portable Fire Extinguishers,			are installed in accordance wit NFPA 10 and to ensure portal		
	2010 Edition, Section				fire extinguishers are inspecte		
		pe conspicuously located			least monthly and the inspection		
	-	ily accessible and immediately			are documented including the		
		nt of fire. This deficient			and initials of the person		
	practice could affect	t 10 residents, staff, and			performing the inspection in		
	visitors in the vicini	ty of the Alzheimer's			accordance with NFPA 10 to n	neet	
	Activities area.				set standards.		
					1.CORRECTIVE ACTIONS		
	Findings include:				TAKEN:		
					a. By 4/7/23 the facilities		
		ons with the Maintenance			Maintenance Supervisor/desig		
	•	ur of the facility from 10:20			relocated the ABC type portab		
	-	02/24/23, the wall mounted			fire extinguisher located in the		
		fire extinguisher located in the ies area was installed above a			Alzheimer's Activities area to		
		atform which extended			meet set standards.		
		orridor wall under the fire			b. By 4/7/23 the facilities  Maintenance Supervisor/desig	inee	
		prevented the fire extinguisher			performed the monthly inspect		
		accessible and immediately			on all ABC type portable fire		
		nt of fire. Based on interview			extinguishers and updated the	<u> </u>	
	at the time of the observations, the Maintenance				inspection date on the tags		
		aforementioned portable fire			including the extinguishers at t	the	
	extinguisher location	ns was not readily accessible			following locations: in the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155280	B. W	ING		02/24/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			LENOVER ST		
\//ATEDS	S OF DILL SBORO	ROSS MANOR, THE			ORO, IN 47018		
VVAILING	. Of DILLODONO-P	WANTE		DILLOB	O.C.O., IIV 77010		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and immediately available in the event of fire.				basement by the water soften		
					and in the basement laundry r	oom	
	These findings were reviewed with the				to meet set standards.		
		he Maintenance Director			1.ALL OTHERS WITH		
	during the exit conf	erence.			POTENTIAL TO BE AFFECTE	D:	
					1.All residents and all sta		
	3.1-19(b)				and visitors have the potential	to	
					be affected but none were.		
		ation and interview, the facility			2.MEASURES TO PREVEN	Γ	
		f 26 portable fire extinguishers			REOCCURRENCE:		
	_	ast monthly and the			1.On 3/24/23 the		
	_	ocumented including the date			Administrator inserviced the		
	_	erson performing the			Maintenance Supervisor/desig		
	_	lance with NFPA 10. LSC			that portable fire extinguishers	are	
		ble fire extinguishers shall be			readily accessible and must be	Э	
		nspected, and maintained in			inspected and maintained to n	neet	
		FPA 10. NFPA 10, the			set standards.		
		le Fire Extinguishers, 2010			2.Maintenance		
		2.1.2 states fire extinguishers			Supervisor/designee will ensu	re	
	_	ither manually or by means of			portable fire extinguishers are		
		oring device/system at a			readily accessible and are		
		intervals. Where monthly			inspected monthly as a part of		
		are conducted, the date the			facility's Preventive Maintenar	ice	
		was performed and the initials			Program and document those		
		rming the inspection shall be			inspection results as appropria		
		anual inspections are			If any issues are discovered, t	-	
		for manual inspections shall			will be addressed and resolve		
		abel attached to the fire			immediately. The Maintenanc		
	_	inspection checklist			Supervisor/designee will revie	W	
		or by an electronic method.	1		with the Administrator the		
		pt to demonstrate that at least			inspection results.		
		inspections have been			3.The Administrator will		
	_	ficient practice could affect			monitor adherence to the		
	over 2 staff and visi	itors in the basement.			Preventative Maintenance		
			1		schedule and validate the		
	Findings include:				Preventative Maintenance		
					documentation is in place.		
		ons with the Maintenance			3.MONITORING CORRECTI	VE	
	_	our of the facility from 10:20			ACTION:		
	a.m. to 2:15 p.m. or	n 02/24/23, the affixed			1.The inspection results v	will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETE	ED
		155280	B. W	NG		02/24/20	23
				_		<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ENOVER ST		
WATERS	GOF DILLSBORO-F	ROSS MANOR, THE		DILLSB	ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintenance tag for	the ABC type portable fire			be presented by the Maintena	nce	
	extinguisher located in the basement by the water softener had missing monthly inspection documentation for November 2022 and December 2022. In addition, the affixed maintenance tag for				Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
		ble fire extinguisher located in			Quality Assurance/Performand	-	
		lry Room had missing monthly			Improvement (QA/PI) meeting		
		ntation for January 2023.			Inspection results and system		
	Based on interview				components will be reviewed by		
	observations, the M	aintenance Director agreed			the QA/PI Committee with	·	
		portable fire extinguisher			subsequent plans of correction	n	
		nissing monthly inspection			developed and implemented a		
	documentation.				deemed necessary to ensure		
					compliance is maintained.		
	These findings were	e reviewed with the			This plan of correction		
	_	he Maintenance Director			constitutes our credible		
	during the exit conf				allegation of compliance with	ո	
	J				all regulatory requirements.		
	3.1-19(b)				Our date of compliance is		
	( )				4/7/23.		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 02	Corridor - Doors						
		corridor openings in other					
	•	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	capable of resisting	g fire for at least 20					
		fully sprinklered smoke					
	•	only required to resist the					
	-	e. Corridor doors and doors					
	to rooms containir	•					
		rials have positive latching					
		atches are prohibited by					
		hese requirements do not					
	apply to auxiliary	spaces that do not contain					
	flammable or com	bustible material.					
	Clearance betwee	n bottom of door and floor					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	02	COMPI		
		155280	B. W	ING		02/24	/2023	
NAME OF I	DROVIDED OD CUDDI IED	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIER		12803 LENOVER ST					
WATERS	OF DILLSBORO-F	ROSS MANOR, THE	DILLSBORO, IN 47018					
(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 DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE	
	_	ceeding 1 inch. Powered						
		vith 7.2.1.9 are permissible device capable of keeping						
	-	hen a force of 5 lbf is						
		no impediment to the						
		rs. Hold open devices that						
	_	door is pushed or pulled are						
	permitted. Nonrate	ed protective plates of						
	unlimited height a	re permitted. Dutch doors						
	meeting 19.3.6.3.6	ି are permitted. Door						
		beled and made of steel or						
		compliance with 8.3,						
	unless the smoke	•						
	-	fire window assemblies are						
	-	n sprinklered compartments						
		ctions in area or fire s or frames in window						
	assemblies.	s of frames in window						
	assemblies.							
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,						
	483, and 485							
	Show in REMARK	(S details of doors such as						
	fire protection ratir	ngs, automatics closing						
	devices, etc.							
		on and interview, the facility	K 0	363	It is the intent of the facility to		04/07/2023	
		ridor doors to 3 of over 50			ensure corridor doors to room			
		ed with positive latching			equipped with positive latching	-		
	_	se latch into the door frame. ice could affect over 10			devices to fully close latch into			
	residents, staff and				1. CORRECTIVE ACTION			
	1001dellio, starr and	· IDICOLD.			TAKEN:	•		
	Findings include:				a. By 4/7/23 the Maintena	nce		
					Supervisor/designee installed			
	Based on observations with the Maintenance				positive latching device in the			
	Director during a to	our of the facility from 10:20			following locations: 1) on the s			
	a.m. to 2:15 p.m. or	n 02/24/23, the set of double			double doors to the closet by			
		by the smoke barrier door by			smoke barrier door by the			
		e vending machines on the			restroom and the vending			
		equipped with a positive			machines on the first floor 2)			
	latching device. Th	e set of double doors to the			of double doors to the closet b	ру		

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	OF CORRECTION	IDENTIFICATION NUMBER  155280	A. BUILDING B. WING	02	COMPLETED 02/24/2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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
	not equipped with a addition, the set of or Room by the Men's were also not equipped device. Based on in observations, the Menths of the aforementioned equipped with positions.	he Maintenance Director		room 53 on the second floor of double doors to the linen reby the men's restroom on the second floor to meet set standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. The Maintenance Supervisor/desi inspected all corridor doors for impediments, failing latching mechanisms, and gaps and fino other negative findings.  3. MEASURES TO PREV REOCCURRENCE: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/desion the requirement that corridors have positive latching devices to meet set standard b. Maintenance Supervisor/designee will inspeall corridor doors throughout facility monthly to ensure the latching mechanisms work properly as a part of the facili Preventive Maintenance Progrand document those inspective sults as appropriate. If any issues are discovered, they waddressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.  c. The Administrator will monitor adherence to the	ED: aff al to the ignee or ound ENT  gnee dor s. ect the ty's gram on y will be ce

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 02/24/2023
	PROVIDER OR SUPPLIE	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. MONITORING CORRECTIVE ACTION:  a. The inspection results be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performar Improvement (QA/PI) meetin 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 wi all regulatory requirements. Our date of compliance is 4/7/23.	e thly nice g. n by on as
K 0372 SS=E Bldg. 02	Barrie Subdivision of Bu Barrier Construct 2012 EXISTING Smoke barriers s 1/2-hour fire resis barriers shall be p atrium wall. Smod	uilding Spaces - Smoke uilding Spaces - Smoke ion hall be constructed to a stance rating per 8.5. Smoke permitted to terminate at an ice dampers are not required ins in fully ducted HVAC in approved sprinkler system			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155280	B. W	ING		02/24/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				LENOVER ST		
WATERS	OF DILLSBORO-F	ROSS MANOR, THE	DILLSBORO, IN 47018				
			I	ID	· 		(Y5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1/10		oke compartments adjacent		1/10			DATE
	to the smoke barri						
	19.3.7.3, 8.6.7.1(1						
	Describe any mechanical smoke control						
	system in REMAR						
	,	ation and interview, the facility	K 0	372	It is the intent of the facility to 0/4 ensure openings through ceiling		04/07/2023
		nings through 1 of 3 ceiling					
	smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and				smoke barriers are protected t	•	
					maintain the fire resistance ra		
					of the smoke barrier and to en	sure	
					smoke barrier walls on the sec	cond	
	similar items that pass through a floor/ceiling				floor are protected to maintain		
	assembly constructed as a smoke barrier, or				fire resistance rating of the sm		
		membrane of a ceiling smoke			barrier wall to meet set standa		
		ected by a system or material			1. CORRECTIVE ACTION	S	
		the transfer of smoke. Where			TAKEN:		
		lso constructed as a fire barrier,			a. By 4/7/23 the Maintena		
	_	ill be protected in accordance			Supervisor/designee will have		
	_	ats of Section 8.3.5 to limit the			repaired the three escutcheon		
	-	time period equal to the fire			rings in Room 74 to meet set		
		sembly and Section 8.5.6. This			standards.	200	
	staff, and visitors.	ould affect over 20 residents,			b. By 4/7/23 the Maintenai Supervisor/designee will have		
	starr, and visitors.				a one hour fire rated material		
	Findings include:				seal the gap between the	i.o	
	i manigo metade.				escutcheon and the suspende	·d	
	Based on observation	ons with the Maintenance			ceiling tile in the corridor outsi		
		our of the facility from 10:20			Room 35 to meet set standard		
	_	n 02/24/23, the following was			c. By 4/7/23 the Maintenar		
	noted:				Supervisor/designee will have		
	a. three of three esc	utcheons for ceiling mounted			a one hour fire rated material		
	sprinklers had dropp	ped down from their installed			seal the second floor ceiling		
		74 which exposed the			penetrations noted in attic floo	ring	
	interstitial space abo	ove.			for two separate electrical		
		ed to cover the opening			conduits above the east wall o	of the	
		on for the ceiling mounted			attic stairwell to meet set		
	_	ridor outside Room 35 on the			standards		
		e caulk had dried which			d. By 4/7/23 the Maintena		
		en the escutcheon and the			Supervisor/designee will have		
	suspended ceiling ti	le.			a one hour fire rated material	to	

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155280	B. WING		02/24/2023	
			CTREE	TARRESS CITY STATE ZIR COR		
NAME OF	PROVIDER OR SUPPLIE	R		F ADDRESS, CITY, STATE, ZIP COD		
\\/ATED		DOCC MANOR THE		B LENOVER ST		
WATER	S OF DILLSBORO-	ROSS MANOR, THE	DILLS	BORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	c. second floor ceil	ing penetrations were noted as		seal the annular space		
	observed in attic flo	poring for two separate		surrounding a vertical sprinkle	er	
		above the east wall of the attic		pipe which penetrated the se		
	stairwell.			floor ceiling to meet set		
	d. the annular space	e surrounding a vertical		standards.		
	_	h penetrated the second-floor		e. By 4/7/23 the Maintena	ance	
		in attic flooring by the west		Supervisor/designee will have		
	wall in the attic wa			a one hour fire rated material	•	
	Based on interview	* *		seal the bundle of cables whi		
		Saintenance Director agreed		penetrated the smoke barrier		
		openings did not ensure the		above the suspended ceiling		
		ers was protected to maintain		the smoke barrier wall door s		
		ating of the smoke barrier.		room 35 to meet set standard	•	
	the fire resistance i	ating of the smoke barrier.		2. ALL OTHERS WITH	13.	
	These findings wer	e reviewed with the		POTENTIAL TO BE AFFECT	·FD·	
	_	the Maintenance Director		a. All residents and all sta		
	during the exit con			and visitors have the potentia		
	during the exit con	iorenee.		be affected but none were. B		
	3.1-19(b)			4/7/23 the Maintenance	,,,	
	3.1 17(0)			Supervisor/designee will have		
	2 Based on observ	ation and interview, the facility		inspected all smoke barrier w		
		f 2 smoke barrier walls on the		& ceilings throughout the facil		
		protected to maintain the fire		for penetrations and found no	-	
	_	the smoke barrier wall. LSC		negative findings.	, 54101	
		quires smoke barriers to be		3. MEASURES TO PREV	ENT	
		rdance with LSC Section 8.5		REOCCURRENCE:		
		nimum ½ hour fire resistive		a. On 3/24/23 the		
		ent practice could affect over 20		Administrator inserviced the		
	_	l visitors near the vicinity of		Maintenance Supervisor/desi	gnee	
		vall by Room 35 on the second		on the requirement that smok		
	floor.	van by 100m 35 on the second		barrier walls & ceilings must b		
	11001.			_		
	Findings include:			free of penetrations and voids	S 10	
	Findings include:			meet set standards.		
	Dagad on absor	one with the Maintenance		b. Maintenance	o et	
		ons with the Maintenance		Supervisor/designee will insp	•	
		our of the facility from 10:20		all smoke barrier walls & ceili	_	
	_	n 02/24/23, the fire caulk around		throughout the facility monthly	-	
		which penetrated the smoke		penetrations and voids as a p	part of	
	barrier wall above	the suspended ceiling above		the facility's Preventive		

the smoke barrier wall door set by Room 35 on the

Maintenance Program and

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155280	B. WI	ING		02/24/2023	
	PROVIDER OR SUPPLIER S OF DILLSBORO-F	ROSS MANOR, THE		STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY:  (EACH DEFICIEN  REGULATORY OR  second floor dried of did not firestop the barrier wall by the binterview at the tim  Maintenance Direct opening in the attic firestopped to main the smoke barrier wall these findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION but which and shrunk which penetration of the smoke bundled cables. Based on e of the observations, the or agreed the aforementioned smoke barrier wall was not tain the fire resistance rating of rall. e reviewed with the the Maintenance Director			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  document those inspection reas a appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will 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 the preventative 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 the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	sults are ssed ae gnee tor  vill nce  hly ce by	
					compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.	h	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Utilities - Gas and						

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AND PLAN O	E CORRECTION	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			
ANDILANO	F CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155280	B. WI	NG		02/24/	2023
	OVIDER OR SUPPLIER	ROSS MANOR, THE	•	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	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
	Equipment using geomplies with NFP Code, electrical with NFP Code. Existing insistervice provided in 18.5.1.1, 19.5.1.1, 1. Based on observate failed to ensure 1 of in resident sleeping NFPA 70, 2011 Edit Faceplates (Cover Pfaceplates shall be in cover the opening as surface. This deficit resident and staff in Findings include:  Based on observation Director during a total a.m. to 2:15 p.m. on wall mounted outlet receptacles at the he Room 35 was missing was on the room sid on interview at the the Maintenance Director electrical outlet box faceplate.  These findings were Administrator and the during the exit confers.  2. Based on observation of the same part of	gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.  9.1.1, 9.1.2 tion and interview, the facility over 2 outlet boxes installed Room 35 was protected. tion. Article 406.6, Receptacle lates), requires receptacle installed so as to completely and seat against the mounting ent practice could affect over 1 Room 35 on the second floor.  The own with the Maintenance for the late of the resident bed in late of the resident bed in late of the corridor wall. Based lime of the observations, the or agreed the aforementioned location was missing its	K 0:		It is the intent of the facility to ensure outlet boxes installed i resident sleeping rooms are protected and to ensure electriunction boxes on top of the freelevator are maintained in a scoperating condition to meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. By 4/7/23 the Maintenan Supervisor/designee installed face plate for the wall mounted outlet box for the two electricar receptacles at the head of the resident bed in room 35 to me set standards.  b. By 4/7/23 the Maintenan Supervisor/designee installed cover plate to the electrical junction box installed on top of freight elevator to meet set standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. By 4/7/23 the Maintenance Supervisor/designee will have inspected all electrical receptared junction boxes throughout facility to ensure the covers were all electrical receptares.	ical eight afe et  S  nce the d I  et  nce the f the	04/07/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	02	COMPLETED	
		155280	B. W	ING		02/24/2	023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED/	0.05.00.000.00	DOOD MANOR THE			LENOVER ST		
WATERS	S OF DILLSBORO-	ROSS MANOR, THE		DILLSE	3ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	safe operating cond	lition. LSC 19.5.1.1 requires			on and found no other negative	re	
	utilities comply wit	th Section 9.1. LSC 9.1.2			findings.		
	requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible				3. MEASURES TO PREVI	ENT	
					REOCCURRENCE:		
					a. On 3/24/23 the		
					Administrator inserviced the		
	with the box and su	itable for the conditions of			Maintenance Supervisor/design	gnee	
	use. Where used, n	netal covers shall comply with			on the requirement that electr		
		irements of 250.110. This			receptacles and junction boxe		
		ould affect over 1 staff.			must have properly installed		
	_				covers to meet set standards.		
	Findings include:				b. Maintenance		
					Supervisor/designee will inspe	ect	
	Based on observations with the Maintenance				all electrical receptacles and		
	Director during a tour of the facility from 10:20				junction boxes throughout the		
		n 02/24/23, one of one electrical			facility monthly to ensure the		
	_	alled on top of the freight			covers are properly installed a	ıs a	
	1 *	ut a cover which exposed the			part of the facility's Preventive		
		iring in the junction box. A			Maintenance Program and		
	_	ng right next to the junction			document those inspection re-	sults	
		ons were made from the attic			as appropriate. If any issues		
	access door to the f	reight elevator shaft. Based			discovered, they will be addre		
	on interview at the	time of the observations, the			and resolved immediately. Th		
	Maintenance Direct	tor agreed the aforementioned			Maintenance Supervisor/design		
	electrical junction b	oox location did not have its			will review with the Administra		
	cover plate installed	d which exposed the spliced			the inspection results.		
	electrical wiring in	the junction box.			c. The Administrator will		
	1				monitor adherence to the		
	These findings wer	e reviewed with the			Preventative Maintenance		
	Administrator and t	the Maintenance Director			schedule and validate the		
	during the exit conf	ference.			Preventative Maintenance		
					documentation is in place.		
	3.1-19(b)				4. MONITORING		
					CORRECTIVE ACTION:		
					a. The inspection results v	vill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the	.	
					Administrator will present the		
					inspection results at the month	nly	

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	OF CORRECTION	IDENTIFICATION NUMBER  155280	A. BUILDING B. WING	02	COMPLETED 02/24/2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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 0541 SS=D Bldg. 02	Chu Rubbish Chutes, In Chutes 2012 EXISTING (1) Any existing lin including pneumat systems, that oper corridor shall be se construction to pre provided with a fire fire protection ratir shall comply with s (2) Any rubbish ch including pneumat systems, shall be p extinguishing prote 9.7. (3) Any trash chute trash collection roc purpose and prote 8.4. (Existing launce			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 4/7/23.	g. n by on as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	LETED
		155280	B. W	NG		02/24/	/2023
				CTREET	ADDRESS CITY STATE ZIR SOD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED/	0.05.00.000.000	DOOD MANOR THE			LENOVER ST		
WATERS	S OF DILLSBORO-	ROSS MANOR, THE		DILLSE	BORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	),TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	automatic sprinkle	ers in accordance with					
	19.3.5.9 or 19.3.5	5.7.)					
	(4) Existing fuel-fe	ed incinerators shall be					
	sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82						
	Based on observation and interview, the facility failed to maintain fusible links installed at the		K 0	541	It is the intent of the facility to		04/07/2023
					ensure to maintain fusible link		
	chute discharge for	2 of 2 laundry chutes in the			installed at the chute discharg	e for	
	basement. LSC 9.5	5.2 requires laundry chutes shall			laundry chutes in the baseme	•	
	be installed and maintained per NFPA 82, 2009				meet set standards.		
	Edition. NFPA 82, Section 5.2.3.2.3 states chute				1. CORRECTIVE ACTION	S	
	discharge door shall be permitted to be held open				TAKEN:		
	by a fusible link. NFPA 82, Section 10.2.2.1(3)				a. By 4/7/23 a Certified		
	requires the link to be removed for testing every				Contractor will inspect the fus	ible	
	four years to ensure	e full closure and positive			link on the self-closing chute		
	latching. NFPA 82	, Section 10.2.3 states a written			discharge door for two of two		
	record of the inspec	ction shall be signed and kept			laundry chutes in the baseme	nt to	
	for inspection by th	ne Authority Having			meet set standards.		
	Jurisdiction. This of	deficient practice could affect			2. ALL OTHERS WITH		
	over 2 staff in the b	pasement.			POTENTIAL TO BE AFFECTI	ED:	
					a. All residents and all sta	ff	
	Findings include:				and visitors have the potential	l to	
					be affected but none were.		
	Based on observation	ons with the Maintenance			3. MEASURES TO PREVI	ENT	
	Director during a to	our of the facility from 10:20			REOCCURRENCE:		
	_	n 02/24/23, the self-closing			a. On 3/24/23 the		
	chute discharge doo	or for two of two laundry			Administrator inserviced the		
		nent were each held in the fully			Maintenance Supervisor/desig	gnee	
	open position with	a fusible link. An inspection			and all staff on the requiremen	nt to	
		to each chute door in the			ensure to maintain laundry ch	utes	
		pection contractor indicating			to meet set standards.		
		pection and testing was			b. Maintenance		
	^	7/18. Based on interview at the			Supervisor/designee will inspe	ect	
		tions, the Maintenance			all laundry chutes throughout	the	
	Director stated insp				facility monthly to ensure they	,	
		each of the two laundry chute			close properly and are not hel		
		thin the most recent four-year			the open position as a part of	the	
	_	ilable for review and agreed it			facility's Preventive Maintenar	псе	
	had been more than	four years since the most			Program and document those	;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED	
		155280	B. W	ING	_	02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
TAG	recent inspection and	nd testing was performed.  The reviewed with the the Maintenance Director at		TAG	inspection results as approprial fany issues are discovered, the will be addressed and resolve 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 who be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed 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	vill nnce hly ce	
					4/7/23.		
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155280	B. W	ING		02/24	/2023
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		12803 L	LENOVER ST		
WATERS	S OF DILLSBORO-F	ROSS MANOR, THE		DILLSBORO, IN 47018			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEFFERET		DATE
		the transmission of a fire simulation of emergency fire					
	_	rills are held at expected					
	and unexpected times under varying conditions, at least quarterly on each shift.  The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded						
		ay be used instead of					
	audible alarms.						
	19.7.1.4 through 19.7.1.7  1. Based on record review and interview, the		$ _{K0}$	712	It is the intent of the facility to		04/07/2023
		cument quarterly fire drills on	KU	/12	ensure to document quarterly	firo	04/07/2023
		nift for 1 of 4 quarters. This			drills on each shift for each qu		
		ffects all residents, staff and			per year and to document		
	visitors.				activation of the fire alarm sys	tem	
					for first and second shift fire di		
	Findings include:				conducted between 6:00 am a	nd	
					9:00 pm for all four quarter to	meet	
	Based on review of	-			set standards.	_	
		the Maintenance Director			1. CORRECTIVE ACTION	S	
		w from 10:00 a.m. to 12:45 p.m. nentation of a third shift fire drill			TAKEN: a. On 3/24/23 the		
		(July, August, September) 2022			a. On 3/24/23 the  Administrator inserviced the		
		or review. In addition,			Maintenance Supervisor/desig	inee	
		first shift fire drill in the fourth			on the requirement that fire dr		
		lovember, December) 2022 was			must be conducted at unexpe		
	_	or review. Based on interview			times under varying conditions		
	at the time of record	d review, the Maintenance			least quarterly on each shift ar	nd	
		facility operates three shifts			documented to meet set		
		documentation of a first and			standards.		
	third shift fire drill				b. By 4/7/23 the Maintenar		
		endar quarters was not			Supervisor/designee will have		
	available for review	V.			conducted a fire drill/training for		
	These findings were	e reviewed with the			each of the three shifts includi	-	
		the Maintenance Director			activation of the fire alarm sys		
	during the exit conf				signal and documented the re-		
	and the can com	<del></del>			in the facilities Life Safety Ring		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155280	B. W	ING		02/24/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LENOVER ST		
\\/\TED	S OF DILL SPOPO	ROSS MANOR, THE			BORO, IN 47018		
WATER	OF DILLOBORO-	RO33 MANOR, THE		DILLOB	50KO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	3.1-19(b)				to meet set standards.		
					2. ALL OTHERS WITH		
		review and interview, the			POTENTIAL TO BE AFFECT	ED:	
	facility failed to document activation of the fire				a. All residents and all sta	ff	
	alarm system for first and second shift fire drills				and visitors have the potential	to	
	conducted between 6:00 a.m. and 9:00 p.m. for 2 of				be affected but none were.		
	4 quarters. LSC 19.7.1.4 states fire drills in health				3. MEASURES TO PREVI	ENT	
	_	hall include the transmission of			REOCCURRENCE:		
	_	al and simulation of emergency			a. Maintenance		
		hen drills are conducted			Supervisor/designee will ensu	re	
		(2100 hours) and 6:00 a.m. (0600			fire drills are conducted at		
	hours), a coded announcement shall be permitted				unexpected times under varyi	-	
		of audible alarms. This			conditions at least quarterly o	ก	
	-	ould affect all residents, staff			each shift and document activ		
	and visitors in the	facility.			of the fire alarm system and d		
					will be documented on the Fir	е	
	Findings include:				Drill Report and that		
					documentation be retained in	the	
		f "Fire Drill Report"			facility's Life Safety Binder as	а	
		h the Maintenance Director			part of the facility's Preventive	<del>)</del>	
	_	w from 10:00 a.m. to 12:45 p.m.			Maintenance Program and		
		nentation for the first shift fire			document those inspection re		
		01/13/23 at 8:01 a.m. indicated			as appropriate. If any issues		
		cted after 6:00 a.m. but before			discovered, they will be addre		
	_	not include activation of the fire			and resolved immediately. The		
		ransmission of the fire alarm			Maintenance Supervisor/desi	_	
	•	f the fire drill. The			will review with the Administra	itor	
		st shift fire drill documentation			the inspection results.		
		n response to "If Silent Alarm,			b. The Administrator will		
	_	was tested". Based on			monitor adherence to the		
		ne of record review, the			Preventative Maintenance		
		tor agreed documentation for			schedule and validate the		
		I first shift fire drill conducted			Preventative Maintenance		
		before 9:00 p.m. did not include			documentation is in place.		
		re alarm system and			4. MONITORING		
		fire alarm signal at the time of			CORRECTIVE ACTION:		
	the fire drill.				a. The inspection results v		
					be presented by the Maintena	nce	
		re reviewed with the			Supervisor/designee to the		
	Administrator and	the Maintenance Director	1		Administrator monthly and the	÷	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280			A. BUILDING B. WING	02	COMPLETED 02/24/2023
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	ADDRESS, CITY, STATE, ZIP COD LENOVER ST BORO, IN 47018	
(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
K 0754 SS=E Bldg. 02	shall not exceed 3 average density of room or space sha gallons/square fee capacity of 32 gall within any 64 squalinen or trash colle capacities greater located in a room area when not atte Containers used s permitted to be ex requirements when than or equal to 96 and containers for	Frash Containers Frash Containers Sh collection receptacles 2 gallons in capacity. The f container capacity in a all not exceed 0.5 at. A total container cons shall not be exceeded are feet area. Mobile soiled action receptacles with than 32 gallons shall be protected as a hazardous ended. olely for recycling are cluded from the above re each container is less 6 gallons unless attended, combustibles are labeled ing FM Approval Standard		Administrator will present the inspection results at the month 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 4/7/23.	ce J. by n as

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G  02	(X3) DATE SURVEY  COMPLETED  02/24/2023	
	PROVIDER OR SUPPLIES	ROSS MANOR, THE	128	EET ADDRESS, CITY, STATE, ZIP COE 803 LENOVER ST LSBORO, IN 47018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APP	CTION (X5)  JLD BE COMPLETION  ROPRIATE DATE
IAU	Based on observatifailed to ensure una receptacles in 1 of floor were stored in hazardous area in a deficient practice of staff, and visitors in storage and transfill.  Findings include:  Based on observatiful Director during a total a.m. to 2:15 p.m. of partially filled soiled unattended partially the corridor outside transfilling room of contained a trash by Based on interview observations, the More that the aforementioned were not being stored hazardous area who	on and interview, the facility attended soiled linen 7 means of egress on the first in a room protected as a accordance with 19.7.5.7. This ould affect over 10 residents, in the vicinity of the oxygen ling room on the first floor.  ons with the Maintenance our of the facility from 10:20 in 02/24/23, one unattended end linen cart and one by filled trash cart were stored in the the oxygen storage and in the first floor. Each cart ag with 32-gallon capacity. For at the time of the facility in a room protected as a	K 0754	It is the intent of the facilial ensure unattended soiled receptacles in means of the first floor are stored in protected as a hazardous accordance with 19.7.5.7 set standards.  1. CORRECTIVE ACTAKEN:  a. On 3/1/23 The Mai Supervisor/Housekeeping Supervisor/designee remone unattended partially soiled linen cart and one unattended partially filled cart that were stored in the corridor outside the oxyg storage and transfilling rothe first floor to meet set standards.  2. ALL OTHERS WIT POTENTIAL TO BE AFF a. All residents and a and visitors have the pote be affected but none were 3. MEASURES TO PREOCCURRENCE:  a. On 3/24/23 the Administrator inserviced Maintenance Supervisor/Housekeeping Supervisor/and all house laundry staff/designee or requirement that receptate in a protected hazardor room to meet set standards. Maintenance Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/Housekeeping Supervisor/designee will receptables are in a protected standard in a protected s	ty to d linen egress on n a room s area in r to meet  TIONS intenance g noved the filled I trash ne en com on  TH ECTED: Ill staff ential to re. REVENT  the glekeeping & n the cles must ous area rds.  g ensure

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	T OF DEFICIENCIES DF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SI COMPLE 02/24/2	TED			
	ROVIDER OR SUPPLIEI OF DILLSBORO-I	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DE DPRIATE	(X5) COMPLETION DATE			
				hazardous area room as a the facility's monthly Environmental Care Manu document those inspection as appropriate. If any issu discovered, they will be ad and resolved immediately. Maintenance Supervisor/d will review with the Adminithe inspection results.  c. The Administrator w monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4. MONITORING CORRECTIVE ACTION:  a. The Drill results will presented by the Maintenance Supervisor/designee to the Administrator will present the Administrator will present the Inspection results at the m Quality Assurance/Perform Improvement (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 ensicompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance is 4/7/23.	al and a results ues are dressed. The esignee strator ill be ance the onthly nance ting. Item ed by ction ed as ure with ts.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155280	B. W	ING		02/24/	2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			LENOVER ST		
WATERS	S OF DILL SBORO-E	ROSS MANOR, THE					
WATERC	OI DILLODONO-I	TOOU WAITON, THE		DILLOL	BORO, IN 47018		
(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 0761							
SS=E							
Bldg. 02							
		view, observation, and	K 0	761	It is the intent of the facility to		04/07/2023
		ty failed to ensure annual			ensure annual inspection and		
		ng of all fire door assemblies			testing of all fire door assembl		
	•	accordance with LSC			are completed in accordance	of	
		nunicating openings in dividing			LSC 19.1.1.4.1.1 to meet set		
	_	d by 19.1.1.4.1 shall be			standards.		
	1 -	orridors and shall be protected			1. CORRECTIVE ACTION	S	
	by approved self-closing fire door assemblies.				TAKEN:		
	(See also Section 8.3.) LSC 8.3.3.1 Openings				a. By 4/7/23 the Maintenar		
	required to have a fire protection rating by Table				Supervisor/designee will have		
	8.3.4.2 shall be protected by approved, listed,				removed the paint from the fire		
		semblies and fire window			rating label on the smoke barr		
		r accompanying hardware,			doors by room 35 on the seco		
		s, closing devices, anchorage,			floor so they are legible to me	et	
		nce with the requirements of			set standards.		
		for Fire Doors and Other			2. ALL OTHERS WITH		
		s, except as otherwise			POTENTIAL TO BE AFFECTE		
	_	de. NFPA 80 5.2.1 states fire			a. All residents and all stat		
		all be inspected and tested not			and visitors have the potential	to	
		and a written record of the			be affected but none were.		
	_	signed and kept for inspection			3. MEASURES TO PREVE	ENT	
	_	80, 5.2.4.1 states fire door			REOCCURRENCE:		
		visually inspected from both			a. On 3/24/23 the		
		verall condition of door			Administrator/corporate Prope	rty	
	assembly.				Manager inserviced the		
	NIEDA 90 5 2 4 2 -4	41.			Maintenance Supervisor/desig		
	following items sha	tates as a minimum, the			on the requirement that annua		
		r breaks exist in surfaces of			inspections of fire rated doors labels must be conducted to	and	
	either the door or fr						
		ame. light frames, and glazing beads			ensure proper operation and documented on the Annual Do	oor	I
		ely fastened in place, if so			Inspections log and maintaine		I
	equipped.	cry rastened in place, if so			the facility to meet set standar		I
		, hinges, hardware, and			b. Maintenance	us.	
		eshold are secured, aligned,			Supervisor/designee will cond	luct	
		er with no visible signs of			the annual door inspections a		
	damage.	or with no visible signs of			labels to ensure proper operat		
	Gamage.				I lancia in cliante biobei obeigi	TIOLI	i

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETE	
		155280	B. W	'ING	_	02/24/20	23
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			LENOVER ST		
WATERS	OF DILLSBORO-F	ROSS MANOR, THE			BORO, IN 47018		
			1		, 	ı	(3/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	(4) No parts are mis	do not exceed clearances			and document the inspection		
	listed in 4.8.4 and 6				results on the Annual Door		
		device is operational; that is,			Inspection log as a part of the		
		pletely closes when operated			facility's Preventive Maintenar		
					Program and document those		
	from the fully open position.  (7) If a coordinator is installed, the inactive leaf				inspection results as appropria		
	closes before the ac				If any issues are discovered, t	-	
					will be addressed and resolve		
	door when it is in the	are operates and secures the			immediately. The Maintenand		
		•			Supervisor/designee will revie	w	
		vare items that interfere or			with the Administrator the		
	prohibit operation are not installed on the door or				inspection results.		
	frame. (10) No field modifications to the door assembly				c. The Administrator will		
		<del>-</del>			monitor adherence to the		
	_	ed that void the label.			Preventative Maintenance		
		edge seals, where required, are			schedule and validate the		
		their presence and integrity.			Preventative Maintenance		
	-	ice could affect over 20			documentation is in place.		
		visitors in the vicinity of the			4. MONITORING		
	corridor door set by	Room 35 on the second floor.			CORRECTIVE ACTION:	.:11	
	TP' 1' ' 1 1				a. The inspection results v		
	Findings include:				be presented by the Maintena	nce	
	D 1 ' C	10 1 : .:			Supervisor/designee to the		
		annual fire door inspection			Administrator monthly and the	•	
	documentation date				Administrator will present the		
		for during record review from			inspection results at the month	•	
		p.m. on 02/23/23, no fire door			Quality Assurance/Performan		
	_	ocumented deficiencies.			Improvement (QA/PI) meeting		
		ons with the Maintenance			Inspection results and system		
		our of the facility from 10:20			components will be reviewed	ру	
	_	1 02/24/23, the set of smoke			the QA/PI Committee with		
	_	om 35 on the second floor			subsequent plans of correction		
	_	ot legible. Based on interview			developed and implemented a	as	
		oservations, the Maintenance			deemed necessary to ensure		
	_	aforementioned fire resistance			compliance is maintained.		
	rating labels were p	ainted and not legible.			This plan of correction		
	Tl Ci., 1'	i 4i4h 4h			constitutes our credible	_	
	These findings were				allegation of compliance with	n	
		he Maintenance Director			all regulatory requirements.		
	during the exit conf	during the exit conference.			Our date of compliance is		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155280		 JILDING	02	COM	PLETED 24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803 L	ADDRESS, CITY, STATE, ZIP COD LENOVER ST ORO, IN 47018		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	3.1-19(b)			4/7/23.		
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a program for personnel. Maintenance are and readily availate and circuits are manufacturer requirements. Systems are performed to the switches are exercised under to year in 20-40 day once every 36 more scheduled test under the simulation automatic or manuformed to the switches are personnel. Maintenergy power source and readily availate and circuits are manufacturer requirements. The switches are performed to the s	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer with a consideration of the inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. In der load conditions include the ted cold start and wall transfer of all EES inducted by competent in the inspected annually, and a dically exercising the eablished according to the inspected annually, and a dically exercising the sablished according to the inspected annually in the inspected annually in the inspected annually, and a dically exercising the sablished according to the inspected annually in the ins				
	and separate from Minimizing the pos emergency power consideration for r	normal power circuits. ssibility of damage of the source is a design				

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CENTERS FO	TERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02		
		155280	B. W	ING		02/24/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	3	12803 LENOVER ST				
WATERS	S OF DILL SBORO-I	ROSS MANOR, THE			BORO, IN 47018		
VV/ ( ) E   ( )	T DIEEGBORG	TOOS WINGTON, THE		DILLO	1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	NFPA 111, 700.1	,					
		view and interview, the facility	K 0	918	It is the intent of the facility to	ı	04/07/2023
	failed to document	36-month period emergency			ensure to document 36 month	h	
	generator testing fo	or 1 of 2 emergency generators			period emergency generator		
		NFPA 99 and NFPA 110.			testing for emergency genera	itors	
	·	Care Facilities Code, 2012			in accordance with NFPA 99	&	
		1.1.1.6.1 states Type 1 and Type			NFPA 110 to meet set standa	ards.	
		ıl system power sources (EPSS)			1. CORRECTIVE ACTION	NS	
		s Type 10, Class X, Level 1			TAKEN:		
	generator sets per N	NFPA 110. NFPA 110, the			a. By 4/9/23 the Maintena	ance	
	Standard for Emerg	gency and Standby Powers			Supervisor / a Certified gener	rator	
	1	tion, Section 8.4.9 states Level 1			contractor will have performe	d a	
	EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall				four hour continuous load tes	t on	
					the gaseous standby generat	or	
	be tested continuou	sly for the duration of its			set using the available load a	nd	
		Section 4.2). Section 8.4.9.2			documented the results in the	9	
	states where the ass	signed class is greater than 4			facilities Life Safety Binder to		
		ermitted to terminate the test			meet set standards.		
	after 4 continuous l	nours. Section 8.4.9.5 states			2. ALL OTHERS WITH		
	the minimum load	for this test shall be specified in			POTENTIAL TO BE AFFECT	ED:	
	8.4.9.5.1, 8.4.9.5.2,	or 8.4.9.5.3. Section 8.4.9.5.3			a. All residents and all sta	aff	
	states for spark-ign	ited EPS's, loading shall be the			and visitors have the potentia	ıl to	
	available EPSS loa	d. This deficient practice could			be affected but none were.		
	affect all residents,	staff, and visitors.			3. MEASURES TO PREV	ENT	
					REOCCURRENCE:		
	Findings include:				a. On 3/24/23 the		
					Administrator inserviced the		
		view with the Maintenance			Maintenance Supervisor/desi	gnee	
	Director from 10:00	0 a.m. to 12:45 p.m. on 02/23/23,			on the requirement that a		
	thirty-six-month pe	riod emergency generator			thirty-six-month emergency		
	testing documentat	ion for four continuous hours			generator test for four continu	ious	
	for the Waters of D	illsboro's natural gas fired			hours is required to meet set		
	emergency generate	or was not available for review.			standards.		
	Based on interview	at the time of record review,			b. The Maintenance		
	the Maintenance D	irector stated the Waters of			Supervisor/designee will ensu	ure a	
	Dillsboro's building has one natural gas fired				thirty six month emergency		
	emergency generate	or and agreed documentation			generator test for four continu	ious	
		nd testing for four hours within			hours is conducted every three		
		ee-year period was not			years and documented in the		

available for review at the time of the survey.

safety binder to meet set

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE  A. BUILDING  B. WING	construction 02	(X3) DATE SURVEY  COMPLETED  02/24/2023	
	PROVIDER OR SUPPLIER	ROSS MANOR, THE	12803	T ADDRESS, CITY, STATE, ZIP COD B LENOVER ST BBORO, IN 47018	
(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
	These findings were	e reviewed with the he Maintenance Director		standards. 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 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 4/7/23.	hly ce g. h by
K 0920 SS=E Bldg. 02	Extens Electrical Equipmonents Extension Cords Power strips in a pused for components patient-care-related	ent - Power Cords and ent - Power Cords and patient care vicinity are only ints of movable ad electrical equipment les that have been			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPI	LETED	
		155280	B. W	ING		02/24	/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	₹			LENOVER ST			
WATED!		ROSS MANOR, THE			BORO, IN 47018			
WATER	5 OF DILLSBORO-	RO33 MANOR, THE		DILLOB	50KO, IN 47018			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	assembled by qua	alified personnel and meet						
	the conditions of	10.2.3.6. Power strips in						
	the patient care v	icinity 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	r) meet UL 1363. In						
	non-patient care r	ooms, power strips meet						
	other UL standards. All power strips are							
	used with general precautions. Extension							
	cords are not used as a substitute for fixed							
	wiring of a structu	re. Extension cords used						
	temporarily are re	moved immediately upon						
	completion of the	purpose for which it was						
	installed and mee	ts the conditions of 10.2.4.						
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8						
	(NFPA 70), 590.3	(D) (NFPA 70), TIA 12-5						
	Based on observati	on and interview, the facility	K 0	920	It is the intent of the facility to		04/07/2023	
	failed to ensure 1 o	f 1 extension cords including			ensure extension cords includ	ing		
	power strips were r	not used as a substitute for			power strips are not used as a	1		
	fixed wiring. LSC	19.5.1 requires utilities to			substitute for fixed wiring to m	eet		
	comply with Section	n 9.1. LSC 9.1.2 requires			set standards.			
	electrical wiring an	d equipment to comply with			1.CORRECTIVE ACTIONS			
	NFPA 70, National	Electrical Code, 2011 Edition.			TAKEN:			
		00.8 requires that, unless			1.On 3/10/23 the			
		ed, flexible cords and cables			Maintenance Supervisor/desig	gnee		
		a substitute for fixed wiring of			removed the power strip from	the		
	a structure. LSC S	ection 4.5.7 states any building			second floor nurse's station by	/		
		or safeguard provided for life			room 55 to meet set standards	S.		
		gned, installed, and approved			2.ALL OTHERS WITH			
		all applicable NFPA standards.			POTENTIAL TO BE AFFECTE	ED:		
	_	tice could affect over 10			1.All residents and all sta	ıff		
		visitors in the vicinity of the			and visitors have the potential	to		
	second-floor nurse'	s station by Room 55.			be affected but none were. O	n		
					3/10/23 the Maintenance			
	Findings include:				Supervisor/designee inspected	d all		
					areas throughout the facility fo	or		
	Based on observati	ons with the Maintenance			multi plug adapters and found	no		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 02/24/2023 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Director during a tour of the facility from 10:20 other negative findings. a.m. to 2:15 p.m. on 02/24/23, two of three **3.MEASURES TO PREVENT** refrigerators which were stacked on top of each REOCCURRENCE: other in the second-floor nurse's station by Room 1.On 3/24/23 the 55 were plugged into a power strip on the floor Administrator inserviced the behind the refrigerators. Based on interview at Maintenance Supervisor/designee the time of the observations, the Maintenance that the facility cannot have power Director agreed a power strip was being used as a strips / multi plug adapters in use substitute for fixed wiring at the aforementioned to meet set standards. location. 2.Maintenance Supervisor/designee will inspect These findings were reviewed with the all rooms throughout the facility Administrator and the Maintenance Director monthly to ensure they do not during the exit conference. have power strips / multi plug adapters in use as a part of the 3.1-19(b) facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVE ACTION: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.

			_				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	LDING	02	COMPL	ETED
		155280	B. WIN	lG		02/24/	/2023
		<u> </u>	—,	CER FIG	DDDEGG CITY OF THE STREET		
NAME OF F	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
14/4	OF DU L 05 05 0	DOCC MANOR THE		12803 LENOVER ST			
WATERS		ROSS MANOR, THE		DILLSB(	ORO, IN 47018		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					Inspection results and system		
					components will be reviewed		
					the QA/PI Committee with	•	
					subsequent plans of correctio	n	
					developed and implemented a		
					deemed necessary to ensure		
				compliance is maintained.			
					This plan of correction		
					constitutes our credible		
					allegation of compliance wit	h	
					all regulatory requirements.		
					Our date of compliance is		
					4/7/23.		
K 0000							
Bldg. 03							
_	A Life Safety Code	Recertification and State	K 00	00	DISCLAIMER STATEMENT:		
		vas conducted by the Indiana			Preparation and/or execution	า	
	•	Ith in accordance with 42 CFR			of this plan of correction in		
	483.90(a).	·			general, or this corrective		
					action in particular, does no	t	
	Survey Date(s): 02	/23/23 & 02/24/23			constitute an admission or	-	
					agreement by this facility of	the	
	Facility Number: 0	000178			facts alleged or conclusions		
	Provider Number:				forth in this statement of		
	AIM Number: 100				deficiencies. The plan of		
		-			correction and specific		
	At this Life Safety	Code survey, The Waters of			corrective actions are prepa	red	
	_	nor was found not in			and/or executed in complian		
		equirements for Participation in			with state and federal laws.		
	•	l, 42 CFR Subpart 483.90(a),			This plan of correction		
		re and the 2012 edition of the			constitutes a written allegati	on	
	•	ction Association (NFPA) 101,			of substantial compliance w		
					Federal Medicare and		
	Life Safety Code, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				Medicaid requirements.		
	Occupancies and 4	10 1/10 10.2.			medicalu requirements.		
	The Waters of Dille	sboro-Ross Manor consisted of			We respectfully request a de	ek	
		ngs. The Waters of Dillsboro,			review for compliance.	3N	
	iwo separate bullul	ngs. The waters of Dillsoore,	ı	ı	review for confibilation.		I

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155280	r í	UILDING	nstruction  03	(X3) DATE COMPL 02/24/	ETED
	PROVIDER OR SUPPLIER	ROSS MANOR, THE		12803 L	DDRESS, CITY, STATE, ZIP COD ENOVER ST ORO, IN 47018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 03	and was determined construction and ful Building 03, is a on determined to be Ty fully sprinklered. Esystem with smoke Waters of Dillsboro building including the corridors, and hadetectors in all resid Waters of Dillsboro building. The Water as a capacity of 12 the time of this visit All areas where resis were sprinkled and services wer	idents have customary access all areas providing facility klered.  Impleted on 03/06/23  - Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an inguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system is areas shall be separated by smoke resisting rs in accordance with 8.4.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/24/2023			
		ROVIDER OR SUPPLIER	ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018				
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
	TAG		LSC IDENTIFYING INFORMATION hat are deficient in		TAG	DEFICIENCY)		DATE
		REMARKS. 19.3.2.1, 19.3.5.9	nat are delicient in					
		b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 galf. Combustible Stot (over 50 square for g. Laboratories (if Hazard - see K32: Based on observation failed to ensure 1 or as fuel fired heater other spaces by smooth of the spaces by smooth of the spaces of the visitors in the vicinity heater room by Room Findings include:  Based on observation Director during a top.m. to 2:00 p.m. or the passage of one in north wall of the naroom by Room 11 is separate this hazard smoke resistant part the time of the observation of the observ	r-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops boms (exceeding 64  n Rooms lons) brage Rooms/Spaces eet) classified as Severe	K 03	321	It is the intent of the facility to ensure hazardous areas such fuel fired heater rooms are separated from other spaces smoke resistant partitions and doors to meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. By 4/7/23 the Maintenance Supervisor/designee will have sealed the two inch hole with one hour fire resistant materia room 11 in Ross manor to me set standards. ALL OTHERS WITH POTENTIAL TO BE AFFECTED:  a. All residents and all staff ar visitors have the potential to be affected but none were. By 4 the Maintenance Supervisor/designee will have inspected all hazardous areas found no other negative finding	by d IS e e a a al by eet  nd be /7/23	04/07/2023

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 03		COMPLETED		
	155280		B. WING			02/24/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF PROVIDER OR SUPPLIER					LENOVER ST		
WATERS	S OF DILL SBORO-	ROSS MANOR, THE			ORO, IN 47018		
VVAILING	, or billoborto-r	TOOU MANON, THE		DILLOD			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	1
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		or did not separate this			2. MEASURES TO PREVE	ENT	
		n other spaces by smoke			REOCCURRENCE:		
	resistant partitions.				a. On 3/24/23 the Administrator		
					inserviced the Maintenance		
		viewed with the Administrator			Supervisor/designee on the		
		ce Director during the exit			requirement that all hazardous		
	conference.				areas must be separated from		
					other spaces by smoke resista		
	3.1-19(b)				partitions and doors to meet s	et	
					standards.		
					a. Maintenance		
					Supervisor/designee will inspe	ect	
					all hazardous area doors		
					throughout the facility monthly		
					ensure all hazardous areas ar		
					separated from other spaces b	- I	
					smoke resistant partitions and		
					doors as a part of the facility's		
					Preventive Maintenance Progr		
					and document those inspectio		
					results as appropriate. If any		
					issues are discovered, they wi	II be	
					addressed and resolved		
					immediately. The Maintenand Supervisor/designee will revie	•	
					with the Administrator the	vv	
					inspection results.		
					b. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4.MONITORING CORRECTIV	E	
					ACTION:	-	
					a. The inspection results will b	e	
					presented by the Maintenance		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
1	i		1		1	I I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155280			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 02/24/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018					
(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			
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system  Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available. system last checked  system test supply source RKS information on non-required or partial r system.	K 0353	inspection results at the month 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 4/7/23.	hly ce J. by n as			

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 02/24/2023 155280 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 12803 LENOVER ST WATERS OF DILLSBORO-ROSS MANOR, THE DILLSBORO, IN 47018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE sprinkler systems in accordance with NFPA 25. sprinkler systems in accordance LSC 9.7.5 requires all sprinkler systems shall be with NFPA 25 to meet set inspected, tested, and maintained in accordance standards. with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire **1.CORRECTIVE ACTIONS** Protection Systems. NFPA 25, 2011 Edition, TAKEN: Section 4.1.4.1 states the property owner or 1.By 4/7/23 a Certified designated representative shall correct or repair Sprinkler Contractor/Maintenance deficiencies or impairments that are found during Supervisor/designee will have the inspection, test and maintenance required by repaired the accelerator and the this standard. Corrections and repairs shall be tamper switch for the dry sprinkler performed by qualified maintenance personnel or system in Ross Manor to meet a qualified contractor. NFPA 25, 4.3.1 requires set standards. records shall be made for all inspections, tests, 2.ALL OTHERS WITH and maintenance of the system components and POTENTIAL TO BE AFFECTED: shall be made available to the authority having 1.All residents and all staff jurisdiction upon request. This deficient practice and visitors have the potential to could affect all residents, staff, and visitors in be affected but none were. Ross Manor. **3.MEASURES TO PREVENT** REOCCURRENCE: Findings include: 1.On 3/24/23 the Administrator inserviced the Based on review of the sprinkler system Maintenance Supervisor/designee inspection contractor's "Work Performed" on the requirement that the documentation dated 11/22/22 with the sprinkler system must be properly Maintenance Director during record review from maintained to meet set standards. 10:00 a.m. to 12:45 p.m. on 02/23/23, the accelerator 2.Maintenance and the tamper switch for the dry sprinkler system Supervisor/designee will ensure in Ross Manor both need replaced. The the sprinkler systems are contractor's 11/22/22 report stated "arrived on maintained as a part of the scene to find accelerator off. Send quote to facility's monthly Preventive replace" and "tamper switch never showed on Maintenance Program and panel...Bad switch". Based on interview at the document those inspection results time of record review, the Maintenance Director as appropriate. If any issues are stated sprinkler system repair or replacement discovered, they will be addressed documentation for Ross Manor on or after and resolved immediately. The 11/22/22 was not available for review. Based on Maintenance Supervisor/designee observations with the Maintenance Director will review with the Administrator during a tour of the facility from 12:45 p.m. to 2:00 the inspection results.

p.m. on 02/23/23, Ross Manor has a supervised

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3.The Administrator will

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>03</u>		03	COMPLETED		
155280		155280	B. WING			02/24/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE			STREET ADDRESS, CITY, STATE, ZIP COD 12803 LENOVER ST DILLSBORO, IN 47018					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DECLUDED ON AN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PROVIDERS PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT		DATE	
	dry sprinkler systen	n.			monitor adherence to the			
					Preventative Maintenance			
	These findings were	e reviewed with the			schedule and validate the			
	Administrator and t	he Maintenance Director			Preventative Maintenance			
	during the exit conference.				documentation is in place.			
					4.MONITORING CORRECT	IVE		
	3.1-19(b)				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 monthly			
					Quality Assurance/Performan			
					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	as		
					deemed necessary to ensure			
					compliance is maintained.			
					This plan of correction			
					constitutes our credible	L		
					allegation of compliance with	TI .		
					all regulatory requirements.  Our date of compliance is			
					4/7/23.			
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