STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING -- B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date(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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review for compliance.**	
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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific**	

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

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	At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro, Building 02, is a two-story facility with a basement and was determined to be of Type V (000) construction and fully sprinklered. Ross Manor, Building 03, is a one-story facility and was determined to be Type V (111) construction and fully sprinklered. Both facilities have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms in the Waters of Dillsboro building and the Ross Manor building. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 03/06/23		**corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review for compliance.**	
K 0100 SS=F Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information,			

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	along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 basements were maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. LSC Section 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. LSC Section 19.1.1.3.2 states because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention procedures and planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 5.2 light hazard occupancies shall be defined as occupancies or portions of other occupancies where the quantity and/or combustibility of contents is low and fires with relatively low rates of heat release are expected. NFPA 13, Section A.5.2 light hazard occupancies shall include nursing homes. This deficient practice could affect all residents staff and visitors. Findings include:	K 0100	The facility is requesting a waiver for this and will have an FSES survey conducted.	07/02/2023

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	Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:45 p.m. on 02/24/23, the basement was separated from the first floor with exposed wood floor joists in the east basement storage room which classifies the construction type of the building as Type V (000). The fenced in area in the basement consisted of large amounts of combustible item storage. Based on interview at the time of the observations, the Maintenance Director agreed the fenced in area in the basement consisted of large amounts of combustible item storage. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0161 SS=F Bldg. 02	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered			

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	3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	1. Based on observation and interview, the facility failed to ensure 1 of 2 floors was constructed with a 1 hour rated floor structure. The minimum building construction classification allowed for a two-story building is Type V (111), requiring the floor/ceiling assembly between the floors to have a one-hour fire resistive rating. The wood joists of the first-floor construction are exposed to the basement space and does not provide a one-hour fire rating. This deficient practice affects all residents who reside in the Waters of Dillsboro building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:45 p.m. on 02/24/23, the basement was separated from the first floor with exposed wood	K 0161	The facility is requesting a temporary waiver and will have an FSES survey conducted and achieve a passing score.	07/02/2023

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	floor joists in the east basement storage room, the southwest basement boiler room and the northwest basement maintenance workshop room which classifies the construction type of the building as Type V (000). Based on interview at the time of the observations, the Maintenance Director stated the first floor is constructed of one-half inch plywood with vinyl flooring throughout the first floor with no fire rated material. The basement ceiling lacking one hour construction was confirmed by the Maintenance Director at the time of observations. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to provide documentation of the fire resistance rating of the second-floor ceiling smoke barrier construction to ensure the attic has the required number of smoke barrier walls extending to the underside of the roof. LSC Section 19.3.7.3 states any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2) *Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted			

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	heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. Section 8.5.2.1 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. Section 8.5.2.2 states smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Section 8.5.2.3 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. Section 8.3.1.2* Fire barriers shall comply with one of the following: (1) The fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. (2) The fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, and from the floor to the bottom of the interstitial space, provided that the construction assembly forming the bottom of the interstitial space has a fire resistance rating not less than that of the fire barrier. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director from 10:00 a.m. to 12:45 p.m. on 02/23/23, facility blueprint documentation was not available for review. Documentation of the fire resistance			

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	rating of the second-floor ceiling smoke barrier was also not available for review. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:45 p.m. on 02/24/23, the exact location of smoke barrier and fire barrier walls could not be determined. The attic was fully sprinklered and was not used for storage but contained no smoke or fire barrier walls extending to the underside of the roof deck above. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to ensure 3 of 14 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 40 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20	K 0211	It is the intent of the facility to ensure means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 2/24/23 the Maintenance Supervisor/designee removed the wheeled cart and	04/07/2023

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	a.m. to 2:15 p.m. on 02/24/23, the following was noted: a. a red cooler installed in a wheeled cart projected 27 inches into the corridor outside the second floor Activity Director's office by Room 53. A second wheeled cart which projected 18 inches into the corridor was also stored in the corridor outside the second floor Activity Director's office by Room 53. The corridor width at the second floor Activity Director's office by Room 53 measured 68 inches. Each measurement taken was made with the Maintenance Director's measuring tape. b. chains attached to the stairwell handrails were used to block the means of egress in the second-floor stairwell by the new elevator by Room 27. c. the exit door in the Alzheimer's Activities room was marked as a facility exit with an exit sign and could be opened by entering a four-digit code. The Maintenance Director entered the code to release the door to open multiple times, but it would only allow 1 second to open the door before relocking. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		cooler outside the second-floor activity director's office by room 53 and removed a second wheeled cart outside the second-floor activity director's office by room 53 to meet set standards. b. On 2/27/23 the Maintenance Supervisor/designee removed the chains attached to the stairwell handles in the second-floor stairwell by the new elevator by room 27 to meet set standards. c. By 4/7/23 the Maintenance Supervisor/designee repaired the door lock at the exit door in the Alzheimer's Activities room to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 2/24/23 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress	

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			throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	

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K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 8 of 14 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50 residents, staff and visitors if needing to exit the facility. Findings include:	K 0222	It is the intent of the facility to ensure the means of egress through exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the second floor by Room 55 to	04/07/2023

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	Based on observations during the initial walk through of the facility at 9:55 a.m. on 02/23/23, the exit door to the outside of the facility on the second floor by Room 55 was marked as a facility exit with an exit sign and could be opened by entering a four-digit code at a keypad near the door but an incorrect code was posted. Based on interview at the time of the observations, the Maintenance Director stated not all residents on the second floor have a clinical diagnosis to be in a secure wing and agreed the posted code to release the door to open was not the correct code. The Maintenance Director stated the facility did not want staff to smoke in this exit discharge which was the roof the adjoining part of the building. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the following was noted: a. the incorrect code was still posted at the exit door by Room 55 on the second floor. b. the exit door to the outside of the facility on the first floor by the Therapy Room was marked as a facility exit with an exit sign. The door also had an affixed no exit sign. The door could be opened by entering a four-digit code at a keypad by the exit door but the incorrect code to open the door was posted. c. the exit door to the outside of the facility on the first floor inside the Therapy Room was marked as a facility exit with an exit sign. The door also had an affixed no exit sign. The door could be opened by entering a four-digit code at a keypad by the exit door but the incorrect code to open the door was posted. d. the exit door to the outside of the facility on the first floor inside the stairwell by Room 7 was marked as a facility exit with an exit sign. The door also had an affixed no exit sign.		meet set standards. b. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the first floor by the Therapy Room and removed the no exit sign to meet set standards. c. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the first floor inside the Therapy Room and removed the no exit sign to meet set standards. d. On 3/17/23 sign on the first floor inside the stairwell by room 7 to meet set standards. e. On 3/17/23 the Maintenance Supervisor/designee removed the no exit sign on the first floor by the Business Office to meet set standards. f. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the first floor in the Lenover Dining Room and removed the no exit sign to meet set standards. g. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the first floor by room 64 and removed the no exit sign to meet	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	e. the exit door to the outside of the facility on the first floor by the Business Office was marked as a facility exit with an exit sign. The door also had an affixed no exit sign. f. the exit door set to the outside of the facility on the first floor in the Lenover Dining Room was marked as a facility exit with an exit sign. The door set also had an affixed no exit sign. The door set could be opened by entering a four-digit code at a keypad by the exit door set but the incorrect code to open the door set was posted. g. the exit door set to the outside of the facility on the first floor by Room 64 was marked as a facility exit with an exit sign. The door set also had an affixed no exit sign. The door set could be opened by entering a four-digit code at a keypad by the exit door set but the incorrect code to open the door set was posted. h. the exit door on the second floor by the freight elevator was marked as a facility exit with an exit sign and could be opened by entering a four-digit code at a keypad by the exit door but the incorrect code to open the door was posted. The Maintenance Director entered what he said was the correct code to release the door to open, but it would not open. The exit door released with fire alarm system activation by use of a manual fire alarm box at 12:12 p.m. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		set standards. h. On 3/17/23 the Maintenance Supervisor/designee posted information on how to obtain the correct code at the exit door to the outside of the facility on the second floor by the freight elevator to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/17/23 the Maintenance Supervisor/designee inspected all doors to ensure information on how to obtain the codes was present and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that information to obtain the codes must be posted at the exit doors to meet set standards. b. Maintenance Supervisor/designee will inspect all means of corridor doors weekly to ensure they have information on how to obtain the codes as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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 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. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0225 SS=E Bldg. 02	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 1. Based on observation and interview, the facility	K 0225	It is the intent of the facility to	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	failed to ensure 2 of 2 exterior stairs comply with the requirements of 7.2.2.3.3.1. Section 7.2.2.3.3.1 states: Stair treads and landings shall be solid, without perforations. Section 7.2.2.3.3.2 states: Stair treads and landings shall be free of projections or lips that could trip stair users. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the facility exit by the elevator by the exit door by Room 7 was marked as a facility exit with an exit sign. The exterior stairs for this facility exit was metal construction without solid risers and treads. In addition, the facility exit on the second floor by Room 26 was also marked as a facility exit with an exit sign. The exit door led to a roof which covered the sidewalk below. An exterior stairs for the facility exit was attached to the roof. The stairs were of metal construction without solid risers and treads. The landing at the top of the stairs is the roof deck. The construction of the stairs creates a riser approximately two inches higher than the plane of the rooftop landing creating a tripping hazard. A rubber mat was placed on top of the riser. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned stairs were without solid risers and treads and an elevated riser was in place for the stairs at the top of the landing. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		ensure exterior stairs comply with the requirements of 7.2.2.3.3.1 and to ensure items stored in fire escape stairways will not interfere with egress and to ensure items stored in interior fire escape stairways would not interfere with egress to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/17/23 the Maintenance Supervisor/designee consulted with an engineer and researched and found out that this area does not need to be an emergency exit. The area in question already has two stairwell exits that lead to the outside. Maintenance Supervisor/designee will remove the exit sign and install a No Exit sign at the doors located by rooms 7 and 26 to meet set standards. b. By 4/7/23, the Maintenance Supervisor/designee removed the extension ladder, bags of rock salt and a wood beam from the enclosed stairwell in the exit discharge by room 55 on the second floor to meet set standards. c. By 4/7/23, the Maintenance Supervisor/designee removed the storage items from underneath the attic stairwell by the Pantry by room 51 on the second floor to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	2. Based on observation and interview, the facility failed to ensure items stored in 1 of 3 fire escape stairways would not interfere with egress. LSC Section 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect 10 residents, staff and visitors using the enclosed exit stairwell by Room 55 on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, an extension ladder was affixed to the enclosed stairwell wall in the exit discharge by Room 55 on the second floor. In addition, bags of rock salt and a wood beam were stored inside the enclosed stairwell at the bottom of the stairwell. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned stairwell was used for storage which could interfere with egress. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure items stored in 1 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3. states enclosed, usable spaces within exit enclosures shall be prohibited, including under stairs, unless otherwise permitted by 7.2.2.5.3.2. Section 7.2.2.5.3.2 states enclosed, usable space shall be permitted under stairs, provided that both of the following criteria are		and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that interior fire escape stairwells must be free of impediments and all exterior exits must be free of projections to meet set standards. b. Maintenance Supervisor/designee will inspect all interior fire escape stairwells throughout the facility weekly to ensure they are free of impediments and projections as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	met: (1) The space shall be separated from the stair enclosure by the same fire resistance as the exit enclosure. (2) Entrance to the enclosed, usable space shall not be from within the stair enclosure. (See also 7.1.3.2.3.) This deficient practice could affect over 1 staff and visitors using the attic stairwell in the vicinity of the second floor Pantry by Room 51. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, a small closet installed underneath the attic stairwell by the Pantry by Room 51 on the second floor was used for the installation of an electric water heater location, two boxes for sterile supplies, a twenty-gallon waste can and light bulbs. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned stairwell was used for storage under the stairs which could interfere with egress. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0232 SS=E Bldg. 02	NFPA 101 Aisle, Corridor, or Ramp Width 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 maintained to provide the convenient removal of nonambulatory patients			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 3 of 6 corridors. In CMS' S&C policy memo 10-18-LSC dated 05/14/10, which revised S&C-04-41 dated 08/12/04, corridor wall-mounted computer touch screens shall only be installed in corridors that are at least six feet wide. This deficient practice could affect over 40 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, a computer touch screen was installed on the corridor wall outside resident sleeping Room 5, Room 14, and Room 27. Each computer touch screen projected into the corridor, respectively, 6.0 inches, 7.5 inches and 6.5 inches. The corridor width at each computer touch screen location measured 68 inches. Each measurement taken was made with the Maintenance Director's measuring tape. Based on interview at the time of the observations, the Maintenance Director agreed the corridor wall mounted computer touch screens projected into corridors measuring less than six feet in clear and unobstructed width. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0232	It is the intent of the facility to ensure to meet the clear width requirement for corridors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23, the Maintenance Supervisor/designee removed the computer touch screens from the corridor wall outside resident sleeping room 5, room 14 and room 27 to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. By 4/7/23, corridors throughout the facility to ensure no items were being stored improperly and reducing the width of the corridor and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that no items are to be stored in corridors which would reduce the corridor width to meet set standards. b. Maintenance Supervisor/designee will inspect all exit access corridors throughout the facility weekly to	04/07/2023

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			ensure no items are being stored in the corridors which would reduce the corridor width as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			4/7/23.	
K 0271 SS=E Bldg. 02	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 1. Based on observations and interview, the facility failed to ensure 3 of 14 exit discharges was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:35 a.m. to 10:00 a.m. on 02/23/23, the exit discharge for the stairwell by the new elevators had topsoil piled across the entire width of the paved path of egress. The exit door for the stairwell was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Director stated the facility is having outdoor sewer or water line repair and agreed the aforementioned exit discharge was not free of obstruction or impediments to full instant use. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, topsoil was still piled in the exit discharge for the stairwell by the new elevators.	K 0271	It is the intent of the facility to ensure exit discharges are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency and to ensure the means of egress in exit discharge to roofs is continuous and safe to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 3/10/23, the Maintenance Supervisor removed the topsoil piled across the width of the paved path of egress and repaired the area with concrete to 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 at the top of the exterior stairs in the exit discharge by room 26 on the second floor to meet set standards. c. On 3/10/23 the	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	In addition, chains were affixed to the exit discharge handrails blocking the exit discharge for the exit door from the Alzheimer's day room and at the top of the exterior stairs in the exit discharge by Room 26 on the second floor. Each of the two exit doors were marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit discharges provided an impediment to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress in 1 of 2 exit discharge to roofs was continuous and safe. LSC Section 7.7.6 states exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where all of the following criteria are met: (1) The roof/ceiling assembly construction has a fire resistance rating not less than that required for the exit enclosure. (2) A continuous and safe means of egress from the roof is available. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility by Room 55 on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the exit door on the second floor by Room 55 is marked as a facility		Maintenance Supervisor installed directional signage to show the path of egress to the enclosed stairwell on the northwest side of the building to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will inspect all exit doors, stairwells exit discharge and paths to public way to ensure they are readily accessible and free of all obstructions or impediments as a part of the facility's Weekly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0281 SS=E Bldg. 02	NFPA 101 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 so the failure of any single lighting fixture (bulb) would not leave the area in darkness to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/1/23 the Maintenance Supervisor/designee replaced the	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, one of two light bulbs in the exit means of egress outside the second-floor exit door by Room 55 was burned out. In addition, the second-floor entrance to the enclosed stairwell outside Room 55 had only one light fixture with one light bulb. Based on interview at the time of the observations, the Maintenance Director agreed one of the two light bulbs in the aforementioned exit discharge was burned out and the exit access for the second-floor enclosed stairwell had only one lighting fixture with one light bulb. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		burned out light bulb outside the second floor exit door by room 55 and installed egress lighting in the second floor entrance to the enclosed stairwell outside room 55 that had only one light fixture with one light bulb to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 3/1/23 the Maintenance Supervisor/designee inspected all means of egress lights throughout the facility to ensure exit lighting is working properly and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the 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 immediately. The Maintenance Supervisor/designee will review with the Administrator the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0291 SS=F Bldg. 02	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1			
	1. Based on observation and interview, the facility failed to ensure 1 of 7 battery powered emergency	K 0291	It is the intent of the facility to ensure battery powered	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the battery-operated lighting system affixed to the wall above the facility's emergency generator installed in the basement failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5		emergency lighting systems are maintained in accordance with LSC Section 7.9 and to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3/1/23 the Maintenance Supervisor/designee replaced the light in the battery operated lighting system that is affixed to the wall above the facility's emergency generator installed in the basement and documented the results on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. 2.On 3/1/23 the Maintenance Supervisor/designee conducted the monthly and annual battery operated light testing on all seven battery operated lighting systems and documented the results on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to provide and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Battery-Operated Emergency Lights and Signs Test Log" documentation with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, monthly and annual battery-operated light testing documentation for the most recent twelve-month period only included a total of four battery operated lighting systems which were tested. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility within the last year and was not certain the facility had more than four battery operated lighting systems or not. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, a total of seven battery operated lighting systems were noted in the facility which included light locations in the Therapy Room area on the first floor. Each battery-operated lighting system illuminated when its respective test button		maintain emergency lighting and conduct the monthly and annual testing and document the results to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain emergency lighting and conduct the monthly and annual testing as a part of the facility's Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. 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. Inspection results and system components will be reviewed by the QA/PI Committee with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was pushed multiple times except for the battery light location installed at the emergency generator location in the basement. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0293 SS=E Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)			
	Based on observation and interview, the facility failed to ensure 1 of 1 doors to the outside of the facility in the second floor Activities/Dining Room were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the door in the second floor Activities/Dining Room.	K 0293	It is the intent of the facility to ensure doors to the outside of the facility in the second floor Activities / Dining Room are not mistaken as a facility exit to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have installed a No Exit Sign at the door to the outside of the building in the second floor Activities/Dining Room to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the door to the outside of the building in the second floor Activities/Dining Room was not posted with a NO EXIT sign. Based on interview at the time of the observations, the Maintenance Director stated the door is not a facility exit and should be equipped with a NO EXIT sign. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to provide and maintain exit and directional exit signs to mark exit paths to reach the exits to meet set standards. b. Maintenance Supervisor/designee will conduct a monthly check of all emergency exit signs and document those inspection results on the Emergency Lights & Signs Test Log as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0311 SS=E Bldg. 02	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			
	1. Based on observation and interview, the facility failed to maintain protection of 3 of 4 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures 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 linen chutes and the two story convenience stairs are in accordance with 19.3.1 and to ensure freight elevators are	07/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Fire doors assemblies are in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, Section 4.8.4.1 states the clearance under to bottom of a door shall be a maximum of 3/4th's inch. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the following was noted: a. the stairwell door on the first floor by Room 7 and on the second floor by Room 37 were each not equipped with a fire resistance rating label. Based on interview at the time of the observations, the Maintenance Director agreed each of the two stairwell doors did not have a fire resistance rating label affixed to the door. b. one layer of 5/8th's inch thick drywall, which was hung vertically, was used to cover the spiral staircase opening at the bottom of the staircase which did not enclose the staircase with a minimum 1-hour fire resistance rating. The one layer of drywall at the bottom of the staircase was part of the corridor wall by the second floor Janitor's closet by the freight elevator. c. a one quarter inch gap was noted in between the top of the door frame and the wall for the stairwell door to the attic. d. the stairwell door to the closet by the attic stairwell door was equipped with a self-closing device but the bottom of the door kept getting stuck on the carpet on the floor and would not self-close and latch into the door frame when tested to close multiple times.		enclosed with at least 1 hour resistance rating to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. **The facility will have a passing FSES survey conducted.** (stairwell door on the first floor by room 7 and on the second floor by room 37) b. **The facility will have an FSES survey conducted to include all 5 smoke zones.** (one layer of 5/8" thick drywall, which was hung vertically, was used to cover the spiral staircase opening at the bottom of the staircase) c. By 4/7/23 the Maintenance Supervisor/designee will have used a 1 hour fire-resistant material to seal the one quarter inch gap noted between the top of the door frame and the wall for the stairwell to the attic to meet set standards. d. By 4/7/23 the Maintenance Supervisor/designee will have repaired the stairwell door to the closet by the attic stairwell door so it self closes and latches fully into the frame to meet set standards. e. By 4/7/23 the Maintenance Supervisor/designee will have repaired the latching mechanism on the soiled linen chute in the electrical room by Room 39 on the second floor and on the first floor by Room 5 to meet set standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview at the time of the observations, the Maintenance Director agreed the stairwell doors were not equipped with fire resistance rating label, the bottom of the spiral staircase in the attic was not enclosed with 1-hour fire resistance rating and the two stairwell doors would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the protection of the soiled linen chutes and the two-story convenience stairs was in accordance with 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the soiled linen chute in the electrical room by Room 39 on the second		f. The facility is requesting a waiver for this and will have an FSES survey conducted. (Stairwell wall on the first story by room 17 and the second floor by room 26 only extends to the underside of the suspended acoustical tile ceiling system) g. By 4/7/23 the Maintenance Supervisor/designee will have repaired the access door to the freight elevator shaft to ensure it self closes and has a positive latching mechanism to meet set standards. h. By 4/7/23 the Maintenance Supervisor/designee will have used a 1 hour fire-resistant material to seal the penetration from the bundle of TV cables that penetrated the wall of the freight elevator shaft above the shaft access door to meet set standards. i. By 4/7/23 the Maintenance Supervisor/designee will have used a 1 hour fire-resistant material to seal the annular space surrounding horizontal sprinkler piping which penetrated the freight elevator shaft to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	floor and on the first floor by Room 5 contains wood as part of the construction of the shaft. The door to the laundry chute on the first floor by the facility's main fire alarm control panel is 1-hour fire resistance rated and is equipped with a self-closing device and a latching mechanism, but the latching mechanism did not latch into the door frame when tested to self-close and latch into the chute door frame when tested to close multiple times. The door would only latch into the door frame if the door handle was manually twisted while closing the chute door. In addition, the stairwell wall on the first story by Room 17 and on the second floor by Room 26 only extends to the underside of the suspended acoustical tile ceiling system. Removing the tile in the ceiling system exposes the wood top plate and edge of the gypsum board wall assembly. The existing two-story convenience stair opening does not appear to be enclosed by a minimum one-hour fire-rated construction. Based on interview at the time of the observation, the Maintenance Director agreed the soiled linen chute and the two-story convenience stairs did not appear to be complete with fire-rated assemblies. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 freight elevators was enclosed with at least 1-hour resistance rating. This deficient practice could affect over two staff and visitors in the attic. Findings include:		Administrator inserviced the Maintenance Supervisor/designee on the requirement that all smoke barrier doors must self close and latch and have fire resistance rating labels and/or have an FSES completed, all smoke barrier walls are free of penetrations, and all chutes, shafts, and stairs are constructed with fire-resistant materials to meet set standards. b. Maintenance Supervisor/designee will inspect monthly throughout the facility all smoke barrier doors are free of penetrations, have fire resistance rating labels and self–closing devices and/or FSES completed, inspect all smoke barrier walls for penetrations, and ensure all chutes, shafts, and stairs are constructed with fire-resistant materials as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the following was noted in the attic: a. the access door to the freight elevator shaft was wood and had one layer of 5/8th's inch thick drywall affixed to the door on the shaft side of the door. In addition, the access door was not self-closing or automatic closing and was not equipped with a positive latching mechanism to latch the door into the door frame. b. a bundle of cable TV cables penetrated the wall of the freight elevator shaft above the shaft access door and the penetration was not firestopped. c. the annular space surrounding horizontal sprinkler piping which penetrated the freight elevator shaft had been filled with fire caulk, but the caulk had dried up exposing the shaft. Based on interview at the time of the observations, the Maintenance Director agreed the top of the freight elevator shaft enclosed with at least 1-hour resistance rating. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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 monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

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WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous areas such as soiled linen and trash collection rooms exceeding 64 gallons size were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, a one quarter inch in	K 0321	It is the intent of the facility to ensure hazardous areas such as fuel fired heater rooms are separated from other spaces by smoke resistant partitions and doors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have sealed the two inch hole with a one hour fire resistant material by room 11 in Ross manor to meet set standards. **ALL OTHERS WITH POTENTIAL TO BE**	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

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	diameter hole was noted above the door handle for the corridor door to the soiled utility room by the Shower Room by Room 10 on the first floor. In addition, the second floor Shower room contained soiled linen and trash carts exceed 64 gallons in size. The corridor door to the room was not equipped with a self-closing device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. By 4/7/23 the Maintenance Supervisor/designee will have inspected all hazardous areas and found no other negative findings. **2. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous areas must be separated from other spaces by smoke resistant partitions and doors to meet set standards. a. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure all hazardous areas are separated from other spaces by smoke resistant partitions and doors as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			documentation is in place. **4.MONITORING CORRECTIVE 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 monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0345 SS=C Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review, observation, and interview; the facility failed to ensure all fire alarm	K 0345	– It is the intent of the facility to ensure fire alarm system initiating	04/07/2023

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	system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(h) states smoke detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Table 14.4.5 at 15(h) states smoke detectors shall be functionally tested annually. NFPA 72, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, Section 14.4.5 states heat detector testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance shall be measured and recorded. Changes from acceptance test shall be investigated. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the fire alarm system		devices are inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72 and to ensure the fire alarm system has accurate time and date information in accordance with requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 – 2010 edition, Sections 14.1, 14.1.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 a Certified fire alarm contractor/designee will have inspected and tested all heat detectors throughout the facility and documented the inspection results to meet set standards. b. On 3/13/23 maintenance director/designee corrected the time on the main fire alarm control panel located in the Waters of Dillsboro building to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that heat detectors must be inspected and tested and the fire alarm control panel must show correct time of	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	inspection contractor's "Heat & Carbon Monoxide Detectors" section of the "Fire Alarm System Inspection" report dated 08/04/22 and 02/17/23 for the Waters of Dillsboro building with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, no heat detectors were listed as being installed in the facility and no heat detectors were listed as inspected or tested within the most recent twelve-month period. Based on interview at the time of record review, the Maintenance Director stated additional fire alarm inspection documentation for the most recent twelve-month period was not available for review and stated the facility has two elevator machine rooms. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 12:45 p.m. on 02/24/23, one heat detector was installed in the elevator machine room on the first floor by Room 7. One heat detector was also installed in the basement elevator machine room. Based on interview at the time of record review and of the observations, the Maintenance Director agreed it could not be ensured the aforementioned fire alarm system inspection documentation included elevator machine room initiating device inspection and testing within the most recent twelve-month period. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72		day to meet set standards. b. Maintenance Supervisor/designee will ensure inspections of heat detectors are conducted and the control panel shows correct time of day as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	- 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour 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 was incorrect. The display read the time of day as 2:05 p.m. at 1:10 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the main fire alarm control panel for the Waters of Dillsboro building did not display the correct time of day. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms			

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 2 of over 2 second floor closets in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the second floor Pantry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, shelf storage within 10 inches of the ceiling mounted sprinkler was noted in the closet with the double doors outside the Activity Director's Office by Room 53 on the second floor. In addition, the back wall of the closet which adjoins the Pantry on the second floor by the stairwell on the second floor does not extend to the ceiling and blocks the spray pattern of the ceiling mounted sprinkler in the Pantry. A sprinkler is not installed in the closet. Based on	K 0351	It is the intent of the facility to ensure the spray pattern for sprinkler heads is not obstructed in 2 of over 2 second floor closets in accordance with LSC 19.3.5.1 to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have removed the shelf storage within 10 inches of the ceiling mounted sprinkler that was noted in the closet with the double doors outside the Activity Directors office by room 53 on the second floor and he repaired the back wall of the closet to have 18" clearance on the second floor by the stairwell to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the spray pattern for sprinklers heads must not be obstructed to meet set	04/07/2023

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	interview at the time of observation, the Maintenance Director agreed the aforementioned two areas have obstructions to sprinkler coverage. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		standards. b. A Certified sprinkler contractor/Maintenance Supervisor/designee will inspect all sprinkler heads monthly to ensure the spray pattern is not obstructed as a part of the facility’s monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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	155280	A. BUILDING 02 B. WING	02/24/2023

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be	K 0353	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/Maintenance Supervisor/designee will have repaired the accelerator and the tamper switch for the dry sprinkler	04/07/2023

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	performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the Waters of Dillsboro. Findings include: Based on review of the sprinkler system inspection contractor's "Work Performed" documentation dated 11/22/22 with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, the accelerator for the dry sprinkler system in the Waters of Dillsboro building needs to be replaced. The contractor's 11/22/22 report stated "send quote to replace accelerator. It would reset but never built pressure". Based on interview at the time of record review, the Maintenance Director stated sprinkler system repair or replacement documentation for the Waters of Dillsboro building on or after 11/22/22 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the Waters of Dillsboro has supervised wet and dry sprinkler systems. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation, and interview, the facility failed to ensure 1 of 4 sprinkler heads in Room 74 covered with dust were replaced or		system in Ross Manor to meet set standards. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are maintained as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of Room 74. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the ceiling mounted sprinkler head nearest the corridor door in Room 74 was covered with spider webs and dust. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler location was covered with spider webs and dust. These findings were reviewed with the		Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.1 states fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the Alzheimer's Activities area. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the wall mounted ABC type portable fire extinguisher located in the Alzheimer's Activities area was installed above a wood bench type platform which extended outward from the corridor wall under the fire extinguisher which prevented the fire extinguisher from being readily accessible and immediately available in the event of fire. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher locations was not readily accessible	K 0355	It is the intent of the facility to ensure portable fire extinguishers are installed in accordance with NFPA 10 and to ensure portable fire extinguishers are inspected at least monthly and the inspections are documented including the date and initials of the person performing the inspection in accordance with NFPA 10 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the facilities Maintenance Supervisor/designee relocated the ABC type portable fire extinguisher located in the Alzheimer's Activities area to meet set standards. b. By 4/7/23 the facilities Maintenance Supervisor/designee performed the monthly inspection on all ABC type portable fire extinguishers and updated the inspection date on the tags including the extinguishers at the following locations: in the	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

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	and immediately available in the event of fire. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 26 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 2 staff and visitors in the basement. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the affixed		basement by the water softener and in the basement laundry room to meet set standards. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee that portable fire extinguishers are readily accessible and must be inspected and maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure portable fire extinguishers are readily accessible and are inspected monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	maintenance tag for the ABC type portable fire 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 the ABC type portable fire extinguisher located in the basement Laundry Room had missing monthly inspection documentation for January 2023. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure corridor doors to 3 of over 50 rooms were equipped with positive latching devices to fully close latch into the door frame. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the set of double doors to the closet by the smoke barrier door by the restroom and the vending machines on the first floor were not equipped with a positive latching device. The set of double doors to the	K 0363	It is the intent of the facility to ensure corridor doors to rooms are equipped with positive latching devices to fully close latch into the door frame to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee installed a positive latching device in the following locations: 1) on the set of double doors to the closet by the smoke barrier door by the restroom and the vending machines on the first floor 2) Set of double doors to the closet by	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	closet by Room 53 on the second floor were also not equipped with a positive latching device. In addition, the set of double doors to the Linen Room by the Men's restroom on the second floor were also not equipped with a positive latching device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors were not equipped with positive latching devices. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		room 53 on the second floor 3) Set of double doors to the linen room by the men's restroom on the second floor to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors for impediments, failing latching mechanisms, and gaps and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that corridor doors have positive latching devices to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure the latching mechanisms work 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 immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0372 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system			

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure openings 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 similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the following was noted: a. three of three escutcheons for ceiling mounted sprinklers had dropped down from their installed locations in Room 74 which exposed the interstitial space above. b. fire caulk was used to cover the opening around the escutcheon for the ceiling mounted sprinkler in the corridor outside Room 35 on the second floor, but the caulk had dried which caused a gap between the escutcheon and the suspended ceiling tile.	K 0372	It is the intent of the facility to ensure openings through ceiling smoke barriers are protected to maintain the fire resistance rating of the smoke barrier and to ensure smoke barrier walls on the second floor are protected to maintain the fire resistance rating of the smoke barrier wall to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have repaired the three escutcheon rings in Room 74 to meet set standards. b. By 4/7/23 the Maintenance Supervisor/designee will have used a one hour fire rated material to seal the gap between the escutcheon and the suspended ceiling tile in the corridor outside Room 35 to meet set standards. c. By 4/7/23 the Maintenance Supervisor/designee will have used a one hour fire rated material to seal the second floor ceiling penetrations noted in attic flooring for two separate electrical conduits above the east wall of the attic stairwell to meet set standards. . d. By 4/7/23 the Maintenance Supervisor/designee will have used a one hour fire rated material to	04/07/2023

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	c. second floor ceiling penetrations were noted as observed in attic flooring for two separate electrical conduits above the east wall of the attic stairwell. d. the annular space surrounding a vertical sprinkler pipe which penetrated the second-floor ceiling as observed in attic flooring by the west wall in the attic was not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings did not ensure the ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 smoke barrier walls on the second floor were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff, and visitors near the vicinity of the smoke barrier wall by Room 35 on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the fire caulk around a bundle of cables which penetrated the smoke barrier wall above the suspended ceiling above the smoke barrier wall door set by Room 35 on the		seal the annular space surrounding a vertical sprinkler pipe which penetrated the second floor ceiling to meet set standards. e. By 4/7/23 the Maintenance Supervisor/designee will have used a one hour fire rated material to seal the bundle of cables which penetrated the smoke barrier wall above the suspended ceiling above the smoke barrier wall door set by room 35 to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. By 4/7/23 the Maintenance Supervisor/designee will have inspected all smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceilings throughout the facility monthly for penetrations and voids as a part of the facility's Preventive Maintenance Program and	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	second floor dried out which and shrunk which did not firestop the penetration of the smoke barrier wall by the bundled cables. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the attic smoke barrier wall was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 2 outlet boxes installed in resident sleeping Room 35 was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over 1 resident and staff in Room 35 on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the faceplate for the wall mounted outlet box for the two electrical receptacles at the head of the resident bed in Room 35 was missing. The outlet box location was on the room side of the corridor wall. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned electrical outlet box location was missing its faceplate. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes on top of the freight elevator were maintained in a	K 0511	It is the intent of the facility to ensure outlet boxes installed in resident sleeping rooms are protected and to ensure electrical junction boxes on top of the freight elevator are maintained in a safe operating condition to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee installed the face plate for the wall mounted outlet box for the two electrical receptacles at the head of the resident bed in room 35 to meet set standards. b. By 4/7/23 the Maintenance Supervisor/designee installed the cover plate to the electrical junction box installed on top of the freight elevator to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. By 4/7/23 the Maintenance Supervisor/designee will have inspected all electrical receptacles and junction boxes throughout the facility to ensure the covers were	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 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 with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 1 staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, one of one electrical junction boxes installed on top of the freight elevator was without a cover which exposed the spliced electrical wiring in the junction box. A cover plate was lying right next to the junction box. The observations were made from the attic access door to the freight elevator shaft. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		on and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical receptacles and junction boxes must have properly installed covers to meet set standards. b. Maintenance Supervisor/designee will inspect all electrical receptacles and junction boxes throughout the facility monthly to ensure the covers are properly installed as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0541 SS=D Bldg. 02	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by			

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	automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed 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 chute discharge for 2 of 2 laundry chutes in the basement. LSC 9.5.2 requires laundry chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.2.3 states chute discharge door shall be permitted to be held open by a fusible link. NFPA 82, Section 10.2.2.1(3) requires the link to be removed for testing every four years to ensure full closure and positive latching. NFPA 82, Section 10.2.3 states a written record of the inspection shall be signed and kept for inspection by the Authority Having Jurisdiction. This deficient practice could affect over 2 staff in the basement. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the self-closing chute discharge door for two of two laundry chutes in the basement were each held in the fully open position with a fusible link. An inspection sticker was affixed to each chute door in the basement by an inspection contractor indicating the most recent inspection and testing was performed on 06/27/18. Based on interview at the time of the observations, the Maintenance Director stated inspection and testing documentation for each of the two laundry chute discharge doors within the most recent four-year period was not available for review and agreed it had been more than four years since the most	K 0541	It is the intent of the facility to ensure to maintain fusible links installed at the chute discharge for laundry chutes in the basement to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 a Certified Contractor will inspect the fusible link on the self-closing chute discharge door for two of two laundry chutes in the basement to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement to ensure to maintain laundry chutes to meet set standards. b. Maintenance Supervisor/designee will inspect all laundry chutes throughout the facility monthly to ensure they close properly and are not held in the open position as a part of the facility's Preventive Maintenance Program and document those	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	recent inspection and testing was performed. These findings were reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		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. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills			

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills 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 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to document quarterly fire drills on the first and third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, documentation of a third shift fire drill in the third quarter (July, August, September) 2022 was not available for review. In addition, documentation of a first shift fire drill in the fourth quarter (October, November, December) 2022 was also not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed documentation of a first and third shift fire drill conducted in the aforementioned calendar quarters was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0712	It is the intent of the facility to ensure to document quarterly fire drills on each shift for each quarter per year and to document activation of the fire alarm system for first and second shift fire drills conducted between 6:00 am and 9:00 pm for all four quarter to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b. By 4/7/23 the Maintenance Supervisor/designee will have conducted a fire drill/training for each of the three shifts including activation of the fire alarm system and transmission of the fire alarm signal and documented the results in the facilities Life Safety Binder	04/07/2023

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(b) 2. Based on record review and interview, the facility failed to document activation of the fire alarm system for first and second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 2 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, documentation for the first shift fire drill conducted on 01/13/23 at 8:01 a.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned first shift fire drill documentation stated "01/20/23" in response to "If Silent Alarm, provide date alarm was tested". Based on interview at the time of record review, the Maintenance Director agreed documentation for the aforementioned first shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Administrator and the Maintenance Director		to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and document activation of the fire alarm system and drills will be documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	during the exit conference. 3.1-19(b)		Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0754 SS=E Bldg. 02	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on observation and interview, the facility failed to ensure unattended soiled linen receptacles in 1 of 7 means of egress on the first floor were stored in a room protected as a hazardous area in accordance with 19.7.5.7. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the oxygen storage and transfilling room on the first floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, one unattended partially filled soiled linen cart and one unattended partially filled trash cart were stored in the corridor outside the oxygen storage and transfilling room on the first floor. Each cart contained a trash bag with 32-gallon capacity. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned soiled linen and trash carts were not being stored in a room protected as a hazardous area when unattended. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0754	It is the intent of the facility to ensure unattended soiled linen receptacles in means of egress on the first floor are stored in a room protected as a hazardous area in accordance with 19.7.5.7 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 3/1/23 The Maintenance Supervisor/Housekeeping Supervisor/designee removed the one unattended partially filled soiled linen cart and one unattended partially filled trash cart that were stored in the corridor outside the oxygen storage and transfilling room on the first floor to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/Housekeeping Supervisor/and all housekeeping & laundry staff/designee on the requirement that receptacles must be in a protected hazardous area room to meet set standards. b. Maintenance Supervisor/Housekeeping Supervisor/designee will ensure receptacles are in a protected	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			hazardous area room as a part of the facility’s monthly Environmental Care Manual 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. 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 Drill 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. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0761 SS=E Bldg. 02	Based on record review, observation, and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.	K 0761	It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have removed the paint from the fire rating label on the smoke barrier doors by room 35 on the second floor so they are legible to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual inspections of fire rated doors and labels must be conducted to ensure proper operation and documented on the Annual Door Inspections log and maintained at the facility to meet set standards. b. Maintenance Supervisor/designee will conduct the annual door inspections and labels to ensure proper operation	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the corridor door set by Room 35 on the second floor. Findings include: Based on review of annual fire door inspection documentation dated 10/11/22 with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, no fire door locations had any documented deficiencies. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, the set of smoke barrier doors by Room 35 on the second floor were painted and not legible. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned fire resistance rating labels were painted and not legible. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(b)		**4/7/23.**	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 1 of 2 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director from 10:00 a.m. to 12:45 p.m. on 02/23/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the Waters of Dillsboro's natural gas fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated the Waters of Dillsboro's building has one natural gas fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three-year period was not available for review at the time of the survey.	K 0918	It is the intent of the facility to ensure to document 36 month period emergency generator testing for emergency generators in accordance with NFPA 99 & NFPA 110 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/9/23 the Maintenance Supervisor / a Certified generator contractor will have performed a four hour continuous load test on the gaseous standby generator set using the available load and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that a thirty-six-month emergency generator test for four continuous hours is required to meet set standards. b. The Maintenance Supervisor/designee will ensure a thirty six month emergency generator test for four continuous hours is conducted every three years and documented in the life safety binder to meet set	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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 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. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been			

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips 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 structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed, and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the second-floor nurse's station by Room 55. Findings include: Based on observations with the Maintenance	K 0920	It is the intent of the facility to ensure extension cords including power strips are not used as a substitute for fixed wiring to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 3/10/23 the Maintenance Supervisor/designee removed the power strip from the second floor nurse's station by room 55 to meet set standards. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 3/10/23 the Maintenance Supervisor/designee inspected all areas throughout the facility for multi plug adapters and found no	04/07/2023

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Director during a tour of the facility from 10:20 a.m. to 2:15 p.m. on 02/24/23, two of three refrigerators which were stacked on top of each other in the second-floor nurse's station by Room 55 were plugged into a power strip on the floor behind the refrigerators. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee that the facility cannot have power strips / multi plug adapters in use to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips / multi plug adapters in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 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.	

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	155280	A. BUILDING 02 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0000 Bldg. 03	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 At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro,	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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review for compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Building 02, is a two-story facility with a basement and was determined to be of Type V (000) construction and fully sprinklered. Ross Manor, Building 03, is a one-story facility and was determined to be Type V (111) construction and fully sprinklered. Both facilities have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms in the Waters of Dillsboro building and the Ross Manor building. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 03/06/23			
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 7 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the natural gas fire water heater room by Room 11 in Ross Manor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:00 p.m. on 02/23/23, a two-inch hole for the passage of one red water line was noted in the north wall of the natural gas fired water heater room by Room 11 in Ross Manor which did not separate this hazardous area from other spaces by smoke resistant partitions. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hole in the north wall of the natural gas fired water heater	K 0321	It is the intent of the facility to ensure hazardous areas such as fuel fired heater rooms are separated from other spaces by smoke resistant partitions and doors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. By 4/7/23 the Maintenance Supervisor/designee will have sealed the two inch hole with a one hour fire resistant material by room 11 in Ross manor to meet set standards. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. By 4/7/23 the Maintenance Supervisor/designee will have inspected all hazardous areas and found no other negative findings.	04/07/2023

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	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	room in Ross Manor did not separate this hazardous area from other spaces by smoke resistant partitions. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**2. MEASURES TO PREVENT REOCCURRENCE**: a. On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that all hazardous areas must be separated from other spaces by smoke resistant partitions and doors to meet set standards. a. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure all hazardous areas are separated from other spaces by smoke resistant partitions and doors as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review, observation, and interview; the facility failed to maintain automatic	K 0353	It is the intent of the facility to ensure to maintain automatic	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in Ross Manor. Findings include: Based on review of the sprinkler system inspection contractor's "Work Performed" documentation dated 11/22/22 with the Maintenance Director during record review from 10:00 a.m. to 12:45 p.m. on 02/23/23, the accelerator and the tamper switch for the dry sprinkler system in Ross Manor both need replaced. The contractor's 11/22/22 report stated "arrived on scene to find accelerator off. Send quote to replace" and "tamper switch never showed on panel...Bad switch". Based on interview at the time of record review, the Maintenance Director stated sprinkler system repair or replacement documentation for Ross Manor on or after 11/22/22 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:00 p.m. on 02/23/23, Ross Manor has a supervised		sprinkler systems in accordance with NFPA 25 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.By 4/7/23 a Certified Sprinkler Contractor/Maintenance Supervisor/designee will have repaired the accelerator and the tamper switch for the dry sprinkler system in Ross Manor to meet set standards. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 3/24/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are maintained as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 03 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	dry sprinkler system. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		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. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/7/23.**	