STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2023				
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	NTE.	(X5) COMPLETION DATE
E 0000	REGULTION	LESC IDENTIFIENCE IN ORNIZITION		1710			DATE
Bldg	conducted by the In accordance with 42 Survey Date: 05/25 Facility Number: 0 Provider Number: 1002 At this Emergency 1 Waters of Hobart SI found not in compli Preparedness Requi Medicaid Participat CFR 483.73	200154 155251 289680 Preparedness survey, The cilled Nursing Facility was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of	E 00	000			
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §48 §483.475(d)(2), §47 §485.625(d)(2), §47 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 184.102(d)(2), §485.68(d)(2), 185.727(d)(2), §485.920(d)					

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

TITLE (X6) DATE

Jarrett MitchellAdministrator06/09/2023

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED.
		155251	B. W	NG		05/25/	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			37TH AVE		
WATERS	OF HOBART SKIL	LLED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	REFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§491.12, and ESF 	RD Facilities at §494.62]:					
	(2) Testing. The [f exercises to test the annually. The [fact following: (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, oppor functional exercise actual exercise (i) of this section include, but is not (A) A second full-scommunity-based functional exercise						
	(B) A mock disast (C) A tabletop exe	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated, emergency scenario, and a					
	set of problem sta						
	I	pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	i ine fracility sj eme	ergency plan, as needed.					

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VLWL21 Facility ID: 000154

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		155251	B. W	NG	·	05/25	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			37TH AVE		
\\/\\TEDS	S OE HOBART SKII	LED NURSING FACILITY, THE			RT, IN 46342		
WATERS	OI HODART SKIL	LED NORSING LACIEITI, THE		HODAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For Hospices at	, , =					
	` <i>'</i>	spices that provide care in					
	1	e. The hospice must					
		s to test the emergency					
	plan at least annu	ally. The hospice must do					
	the following:						
		full-scale exercise that is					1
	community based						
		nunity based exercise is not					
		ct an individual facility					
		exercise every 2 years; or					
	1 ' '	experiences a natural or					
		ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
	I	based exercise or individual					
	1	tional exercise following the					
	onset of the emer	-					
	1 ' '	dditional exercise every 2					
	l •	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted, that may					
		limited to the following:					
	1 ' '	scale exercise that is					
	1 -	or a facility based					
	functional exercise						
	(B) A mock disas						
	` '	ercise or workshop that is					
		and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	nergency plan.					
	(2) Taskin in famil	suis as that musicials in a stirus					
	l ' '	spices that provide inpatient					
	1	hospice must conduct					
		he emergency plan twice					
	1	spice must do the following:					1
l	ı (I) Participate in a	an annual full-scale exercise	1		I		1

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VLWL21 Facility ID: 000154

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUII B. WIN	LDING		COMPL 05/25/	ETED
	F PROVIDER OR SUPPLIEF RS OF HOBART SKIL	LLED NURSING FACILITY, THE		2901 W	ddress, city, state, zip cod 37TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accessible, condu- facility-based func (B) If the hospice man-made emerg of the emergency exempt from enga- full-scale commun- functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full- community-based functional exercise (B) A mock disas (C) A tabletop ex- facilitator that inclusing a narrated, emergency scena- statements, direct questions designe emergency plan. (iii) Analyze the h- maintain documer exercises, and em- the hospice's emer	nunity-based exercise is not lect an annual individual extional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the exercise that is or a facility based e; or ter drill; or ercise or workshop led by a ludes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared					
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following:					

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Event ID:

VLWL21 Facility ID: 000154

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	LETED
		155251	B. W	NG		05/25	/2023
		<u> </u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			37TH AVE		
WATERS	S OF HOBART SKIL	LLED NURSING FACILITY, THE			RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	'	ct an annual individual,					
	· ·	ctional exercise; or					
	(B) If the [PRTF, Hospital, CAH] experiences						
		or man-made emergency					
	1	ation of the emergency					
		is exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
	_	et of the emergency event.					
		an [additional] annual					
		at may include, but is not					
	limited to the following:						
	(A) A second full-scale exercise that is						
	community-based						
	1	ctional exercise; or					
	1 ' '	ock disaster drill; or					
		exercise or workshop that					
		or and includes a group					
	discussion, using						
	1	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	\ , , ·	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	60.84(d):]					
		PACE organization must					
	. ,	s to test the emergency					
	plan at least annu	- -					
	organization must	-					
	_	an annual full-scale exercise	Ī				
	that is community						
		nunity-based exercise is not	Ī				
	, ,	et an annual individual,					
		ctional exercise; or					
	1	xperiences an actual natural					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	UILDING	NSTRUCTION	COM	ie survey ipleted 25/2023
	PROVIDER OR SUPPLIES	R LLED NURSING FACILITY, THE	2901 W	DDRESS, CITY, STATE, ZIP COI 37TH AVE T, IN 46342	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF	ULD BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ergency that requires				
		mergency plan, the PACE				
		ngaging in its next required				
		nity based or individual,				
	-	ctional exercise following the				
	onset of the emer					
		an additional exercise every				
		the year the full-scale or				
		e under paragraph (d)(2)(i)				
of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility						
	based functional					
	(B) A mock disas					
	` '	ercise or workshop that is				
	` '	and includes a group				
	discussion, using	— ·				
	_	emergency scenario, and a				
		atements, directed				
	messages, or pre	pared questions designed				
	to challenge an e	mergency plan.				
	(iii) Analyze the F	PACE's response to and				
	maintain docume	ntation of all drills, tabletop				
		nergency events and revise				
	the PACE's emer	gency plan, as needed.				
	*[For LTC Facilitie					
		ity] must conduct exercises				
	_	ency plan at least twice per				
	1 -	announced staff drills using				
	ICF/IID] must do f	ocedures. The [LTC facility,				
	I -	an annual full-scale exercise				
	that is community					
	1	nunity-based exercise is not				
	` '	uct an annual individual,				
	facility-based fund					
	1	cility] facility experiences an				
	` '	man-made emergency that				

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Event ID:

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	MENT OF DEFICIENCIES LAN OF CORRECTION	IDENTIFICATION NUMBER 155251	 JILDING	nstruction 	COMPL 05/25	ETED
	OF PROVIDER OR SUPPLIED ERS OF HOBART SKII	R LLED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(X4) II PREFI TAG	K (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	LTC facility is exerequired a full-scalindividual, facility-following the onset (ii) Conduct an athat may include, following: (A) A second full-community-based based functional (B) A mock disast (C) A tabletop existed by a facilitator discussion, using clinically-relevant set of problem staressages, or preto challenge an el (iii) Analyze the [response to and rall drills, tabletop events, and revise emergency plan, set (2) Testing. The leaver cises to test the twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID enatural or man-materization of the elis exempt from enatured is exempt from enatured in a full in the community of the elis exempt from enatured in a full in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elis exempt from enatured in the community of the elistent enatured in the elistent	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. §483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the				

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Event ID:

VLWL21 Facility ID: 000154

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUC	CTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		COMPLETED
155251 B. WING		05/25/2023
STREET ADDRESS	S, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 2901 W 37TH	AVE	
WATERS OF HOBART SKILLED NURSING FACILITY, THE HOBART, IN 4	46342	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID	PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS	CROSS-REFERENCED TO THE APPROPRIATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	DEFICIENCY)	DATE
facility-based functional exercise following the		
onset of the emergency event.		
(ii) Conduct an additional annual exercise		
that may include, but is not limited to the		
following: (A) A second full-scale exercise that is		
community-based or an individual,		
facility-based functional exercise; or		
(B) A mock disaster drill; or		
(C) A tabletop exercise or workshop that is		
led by a facilitator and includes a group		
discussion, using a narrated,		
clinically-relevant emergency scenario, and a		
set of problem statements, directed		
messages, or prepared questions designed		
to challenge an emergency plan.		
(iii) Analyze the ICF/IID's response to and		
maintain documentation of all drills, tabletop		
exercises, and emergency events, and revise		
the ICF/IID's emergency plan, as needed.		
*[For HHAs at §484.102]		
(d)(2) Testing. The HHA must conduct		
exercises to test the emergency plan at		
least annually. The HHA must do the		
following:		
(i) Participate in a full-scale exercise that is		
community-based; or		
(A) When a community-based exercise		
is not accessible, conduct an annual		
individual, facility-based functional exercise		
every 2 years; or.		
(B) If the HHA experiences an actual		
natural or man-made emergency that requires		
activation of the emergency plan, the HHA is exempt from engaging in its next required		
full-scale community-based or individual,		
facility based functional exercise following the		
onset of the emergency event.		
(ii) Conduct an additional exercise every 2		

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUILDING B. WING	onstruction 	COMPLETED 05/25/2023
	F PROVIDER OR SUPPLIEF RS OF HOBART SKII	LLED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	years, opposite the functional exercises of this section is continuously based facility-based facility-based facility-based facility-based facility-based facility-based facility-based facility-based funce (B) A mock of (C) A tabletong is led by a facilitate discussion, using clinically-relevant set of problem state messages, or present to challenge an electric (iii) Analyze the Hemaintain document exercises, and enter the HHA's emergent (i) Conduct a paper or workshop at leatexercise is led by group discussion, relevant emergen problem statement prepared question emergency plant actual natural or requires activation OPO is exempt for required testing endit of the emergency (ii) Analyze the Olimaintain documents	e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and nation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise est annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an afthe OPO experiences an anan-made emergency plan, the ome engaging in its next exercise following the onset	TAG	DETCENCTI	DATE

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155251	B. W	ING		05/25/	2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	<u> </u>	2901 W	ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE RT, IN 46342		
WATER	OF HODART SKIL	LED NORSING FACILITY, THE	-	HODAN	(1, IN 40342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	I	OPO's] emergency plan, as					
	needed.						
	*[RNCHIs at §400	2 7/01-					
	-	e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th						
		er-based, tabletop exercise					
		A tabletop exercise is a					
		led by a facilitator, using a					
	narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.						
		NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 00)39	DISCLAIMER STATEMENT:		06/23/2023
		tercises to test the emergency			Preparation and/or execution	1	
	plan at least twice p				of this plan of correction in		
		drills using the emergency °C facility must do the			general, or this corrective		
	following:	C facility must do the			action in particular, does not		
	_	annual full-scale exercise that			constitute an admission or agreement by this facility of	tho	
	is community-based				facts alleged or conclusions		
		ity-based exercise is not			forth in this statement of		
		an annual individual,			deficiencies. The plan of		
	facility-based funct				correction and specific		
	I	y experiences an actual natural			corrective actions are prepar	ed	
	or man-made emerg	gency that requires activation			and/or executed in complian		
	of the emergency p	lan, the LTC facility is exempt			with state and federal laws.		
		ext required full-scale in a			This plan of correction		
		or individual, facility-based			constitutes a written allegation	on	
		l exercise for 1 year following			of substantial compliance wi	th	
	the onset of the actu				Federal Medicare and		
	' '	itional exercise that may			Medicaid requirements.		
		imited to the following:			E039 – It is the intent of the fa	•	
	a. A second full-sca				to ensure to conduct exercises		
	community-based of	or an individual, facility-based			test the emergency plan at lea	st	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLET	
		155251	B. W	ING		05/25/20	J23
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		HOBAF	RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	functional exercise.				twice per year, including		
	b. A mock disaster				unannounced staff drills using		
	c. A tabletop exercise or workshop that is led by a				emergency procedures to med	et	
		des a group discussion, using			set standards.	_	
	·	y-relevant emergency scenario,			1. CORRECTIVE ACTIONS	·	
	_	n statements, directed	1		TAKEN:		
		red questions designed to			a. On 6/9/23 the Administra	alor	
	challenge an emerg				and the Maintenance		
		C facility's response to and			Supervisor/designee conducte	eu a	
		ation of all drills, tabletop			community or facility-based		
	exercises, and emergency events, and revise the				exercise and completed documentation for the exercis	a ta	
	LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This				meet set standards.	e to	
	deficient practice could affect all occupants.				2. ALL OTHERS WITH		
	deficient practice et	ould affect all occupants.			POTENTIAL TO BE AFFECTI	-n·	
	Findings include:				a. All residents and all staff		
		eview with the Maintenance			and visitors have the potential		
		5/23 between 09:23 a.m. and			be affected but none were.	10	
		as full documentation for the			3. MEASURES TO PREVE	NT	
		onducted on 10/15/22 but			REOCCURRENCE:		
	_	a community or facility-based			a. On 6/9/23 the Administra	ator	
		ilable at the time of the survey.			in serviced the Maintenance		
		at the time of records review,			Supervisor/designee on the		
		pervisor stated a community			requirement that a community	or	
		ercise could have been			facility-based exercise must b		
	1	umentation could not be			conducted annually and		
	found. During an in	terview later with the			documentation retained to me	et	
	Administrator, he st	tated that the facility had	1		set standards. (Attachment G) [
	switched over comp	panies and documentation was			b. Maintenance		
	lost in the process.	Furthermore, the			Supervisor/designee will work	with	
		d a power outage occurred,			the Administrator to ensure a		
		ail for incident reporting. No			community or facility-based		
	after-action report of	or detailed summary had been			exercise is conducted and		
	documented.				documented to meet set		
					standards. If any issues are		
	_	ussed with the Maintenance			discovered, they will be addre	ssed	
	Supervisor and Maintenance Assistant #1 at exit				and resolved immediately.		
	conference.				c. The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol	licy	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2023
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE
				Manual and validate the documentation is in place 4. MONITORING CORRECTIVE ACTION: a. At least annually to a compliance, the Administr Maintenance Supervisor/a will review the Emergency Preparedness Policy Man conduct required exercise make changes as necessimeet set standards. Those reviews will be documented appropriate. The Administ present the training results Quality Assurance/ Perfor Improvement (QA/PI) mean Results and system composill be reviewed by the QA/Committee with subseque of correction developed and implemented as deemed necessary to ensure composits maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance in 6/23/23.	ensure rator and designee / ual and s and ary to se ed as rator will s at the mance eting. onents A/PI ent plans end bliance with ents.
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MUI A. BUI B. WIN	LDING	nstruction 01	(X3) DATE : COMPL 05/25/	ETED
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	DDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Facility Number: 0 Provider Number: AIM Number: 100	155251					
	Hobart Skilled Nurs compliance with Re Medicare, 42 CFR S from Fire and the 20 Protection Associat	Code survey, The Waters of sing Facility was found not in quirements for Participation in Subpart 483.90(a), Life Safety 012 edition of the National Fire ion (NFPA) 101, Life Safety eer 19, Existing Health Care 0 IAC 16.2.					
	west wing and admit basement was deter construction and wa one story addition, of constructed prior to Type V (111) was a	ory facility consisting of the inistrative area with a partial mined to be of Type II (222) as fully sprinklered. A later consisting of the east wing March 2003, determined to be lso fully sprinklered, therefore one building in accordance 9.					
	smoke detectors in to to the corridors. Ba detectors are installed building is partially powered emergency	the corridors and spaces open the corridors and spaces open the corridors and spaces open the corridors. The protected by a 230 kW diesely generator. The facility has and had a census of 42 at the					
	Quality Review con	npleted on 05/30/23					
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - Means of Egress - Aisles, passagewa discharges, exit lo	General					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155251	B. Wl	NG		05/25	/2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			/ 37TH AVE		
\\/\TED	S OF HOBART SKI	LLED NURSING FACILITY, THE			RT, IN 46342		
WATER	3 OF HODAKT SKI	ELED NORSING FACILITY, THE		HOBAN	(1, IN 40342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	in accordance wit	h Chapter 7, and the means					
	of egress is conti	nuously maintained free of					
	all obstructions to	full use in case of					
	emergency, unles	ss modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.	1.10.1					
	Based on observ	ation and interview, the facility	K 0	211	K211 – It is the intent of the		06/23/2023
		f 6 means of egress were			facility to ensure means of eg	ress	
	1	rained free of all obstructions			are continuously maintained f	ree	
	_	full instant use in the case of			of all obstructions or impedime	ents	
	_	ency. This deficient practice			to full instant use in the case	of	
	could affect all app	roximately 15 staff and			fire or other emergency and		
	residents.				maintain exit discharge doors	are	
					free of impediments to full ins	tant	
	Findings include:				use in the case of fire or other		
					emergency to meet set standa	ards.	
	Based on an observ	vation during a tour of the			1. CORRECTIVE ACTIONS	3	
	facility with the Ma	aintenance Supervisor and			TAKEN:		
	Maintenance Assis	tant #1 on 05/25/23 between			a. On 5/26/23 the Maintena	ance	
	11:50 a.m. and 1:5:	5 p.m., the South 100 Hall			Supervisor/designee removed	l the	
	corridor contained	over 20 cardboard boxes.			cardboard boxes from the sou	ıth	
	Based on an intervi	iew at the time of observations,			100 hall corridor to meet set		
	the Maintenance St	upervisor agreed there was a			standards. The Administrator		
	lot of storage in the	e corridor and stated a delivery			verified the work on 5/26/23.		
	came and they show	ald have been unpacked and			b. On 5/26/23 the		
	taken to designated	l areas.			Maintenance Supervisor/design	gnee	
					repaired the exit door in the m	ain	
	The findings were	reviewed with the Maintenance			dining area to meet set standa	ards.	
	Assistant #1 and th	e Maintenance Supervisor			The Administrator verified the	work	
	during the exit con	ference.			on 5/26/23.		
					2. ALL OTHERS WITH		
	3.1-19(b)				POTENTIAL TO BE AFFECT	ED:	
					a. All residents and all staf	f	
		ation and interview, the facility			and visitors have the potential	to	
		of 7 exit discharges doors were			be affected but none were. O	n	
		s to full instant use in the case			5/26/23 the Maintenance		
	of fire or other eme	ergency in accordance with LSC			Supervisor/designee inspecte	d all	
	7.1.10.1. LSC 7.2.1	1.7.1 states where a door			corridors and exit doors and for	ound	
	assembly is require	ed to be equipped with panic or			no other negative findings.		
	fire exit hardware	(3) It shall be constructed so	1		3 MEASURES TO DREVE	NT.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155251	B. W	ING		05/25/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
VA/A TED	OF HODART OKU	LED NUDOINO EACULITY THE			7 37TH AVE		
WATERS	OF HOBART SKIL	LLED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	that a horizontal for	rce not to exceed 15 lbf (66 N)			REOCCURRENCE:		
	actuates the cross bar or push pad and latches.				a. On 6/9/23 the Administra	ator	
		ice could affect approximately			in serviced the Maintenance		
20 staff and residents near the Main Dining area.				Supervisor/designee and all o	ther		
		5			staff on the requirement that the		
	Findings include:				corridor means of egress are t		
					remain free of obstructions an		
	Based on observations with the Maintenance				exit discharge doors are to rer		
		intenance Assistant #1 on			free of impediments to full inst		
	_	1:50 a.m. and 1:55 p.m., the exit			use to meet set standards.	ant	
		ining area was equipped with			b. Maintenance		
		t the door would not open on			Supervisor/designee will inspe	oct	
	1 ~	the Maintenance Supervisor			all corridor means of egress	.01	
		he door and took excessive			throughout the facility weekly	or	
	1	oor on the fourth try. Based on			obstructions and will inspect a		
	_	e of observation, the			exit discharge doors for	11	
		visor agreed it took excessive			impediments as a part of the		
	_	tit door and was unaware of			facility's Preventive Maintenar	100	
	the issue	it door and was unaware or			Program and document those	ic e	
	the issue				inspection results as appropria	ato	
	The findings were r	reviewed with the Maintenance			If any issues are discovered, t		
	_	e Maintenance Supervisor			will be addressed and resolve	-	
	during the exit conf	-			immediately. The Maintenance		
	during the exit com	crence.			Supervisor/designee will revie		
	3.1-19(b)				with the Administrator the	vv	
	3.1-17(0)				inspection results. (Attachmen	+ A \	
					c. The Administrator will	(LA)	
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:	:11	
					a. The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	

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	OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUILDING B. WING	01	COMPLETED 05/25/2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-ado not exceed 48 if the door.	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. F-closing or and permitted to have pplied protective plates that inches from the bottom of that are deficient in		Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed If the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.	by n as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155251	B. W	ING	·	05/25	/2023
				CTREET	ADDRESS CITY STATE ZIR SOD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD V 37TH AVE		
\\\\ATED	S OF HODART SKI	LLED NURSING FACILITY, THE			RT, IN 46342		
WATERS	S OF HUBART SKI	LLED NORSING FACILITY, THE		пОВАГ	R1, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a. Boiler and Fue	I-Fired Heater Rooms					
	b. Laundries (larg	er than 100 square feet)					
	c. Repair, Maintenance, and Paint Shops						
	d. Soiled Linen R	ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 ga	llons)					
		orage Rooms/Spaces					
	(over 50 square for	•					
	,	classified as Severe					
	Hazard - see K32	,					
		on and interview, the facility	K 0	321	K321– It is the intent of the fac	cility	06/23/2023
		corridor doors to 1 of 1 linen			to ensure the corridor door to		
	_	h is a hazardous area			hazardous area doors, such a		
		tible storage and greater than			storage room door, is provide		
	_	provided with a self-closing			with a self-closing device to m	ieet	
	device which woul				set standards.	_	
		e and latch into the door frame.			1. CORRECTIVE ACTIONS	S	
	-	tice could affect approximately			TAKEN:		
	15 residents and sta	arr			a. On 5/26/23 the		
	Ein din oo in alada.				Maintenance Supervisor/design	-	
	Findings include:				replaced/repaired the self clos device on the linen storage ro	-	
	Dagad an abanyati	ons during a tour of the facility			door so that it self closes and		
	with the Maintenar	-			latches into the frame to meet		
		tant #1 on 05/25/23 between			standards. The Administrator	. 561	
		5 p.m., the linen storage room, a			verified the work on 5/26/23.		
	1	room that was greater than 50			2. ALL OTHERS WITH		
	_	uipped with self-closing device			POTENTIAL TO BE AFFECTI	FD·	
	1 -	to the frame when tested.			a. All residents and all staf		
		at the time of observation, the			and visitors have the potential		
		visor agreed the room was			be affected but none were. O		
	_	as larger than 50 square feet,			5/26/23 the Maintenance		
		latching mechanism would			Supervisor/designee inspecte	d all	
	need to be replaced				hazardous area doors for self		
					closing devices and found no		
	Findings were disc	ussed with the Maintenance			negative findings.	•	
		intenance Assistant #1 at exit			3. MEASURES TO PREVE	NT	
	conference.				REOCCURRENCE:		
					a. On 6/9/23 the Administr	rator	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 05/25/	ETED
	PROVIDER OR SUPPLIE	LLED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE
	3.1-19(b)			in-serviced the Maintenar Supervisor/designee/all signee and the requirement that all had area doors must be prote a self-closing device and closes and latches into the to meet set standards. b. Maintenance Supervisor/designee will all hazardous area doors throughout the facility more ensure there is a self-closed device and it self closes a latches into the frame as the facility's Preventive Maintenance Program and document those inspection as appropriate. If any issed discovered, they will be an and resolved immediately Maintenance Supervisor/will review with the Admir the inspection results. (Attachment B) 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 at the requality Assurance/Perfor Improvement (QA/PI) me	taff on azardous cted with self self self self self self self self	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/25/2023	
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23	n Is
K 0346 SS=F Bldg. 01	services for more period, the authori be notified, and th evacuated or an a provided for all pa	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has			
	Based on record reversal failed to provide a composition of procedures to be followed alarm system has to four hours or more accordance with LS deficient practice affindings include: Based on records records records records accords records recor	riew and interview, the facility omplete 1 of 1 written policy residents indicating lowed in the event the fire be placed out of service for in a twenty four hour period in C, Section 9.6.1.6. This fects all occupants.	K 0346	K346— It is the intent of the factor ensure to provide a comple written policy for the protection residents indicating procedure be followed in the event the fir alarm system has to be placed out of service for four hours or more in a twenty-four-hour per in accordance with LSC, Section 9.6.1.6 to meet set standards. 1) CORRECTIVE ACTIONS TAKEN: a) On 5/26/23 the	te n of es to e d riod on
	-	watch plan failed to include		Administrator/Maintenance	

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	OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUILDING B. WING	01	COMPLETED 05/25/2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	the IDOH Gateway https://gateway.isdh or by the secondary Gateway is nonoper Incident Reporting i incidents@isdh.in.g the record review, tl acknowledged the fi provided stated to c the IDOH Gateway listed above. This finding was rev	na Department of Health via link atin.gov as the primary method method when the IDOH ational by completing the form and e-mailing it to ov. Based on interview during ne Maintenance Supervisor are watch documentation ontact the IDOH but not via link or at the e-mail address viewed with the Maintenance aintenance Supervisor during		Supervisor updated the fire way plan to include contacting the Indiana Department of Health the IDOH gateway link https://gateway.isdh.in.gov as primary method or by the secondary method by comple the Incident Reporting form an emailing it to incidents@isdh.in.gov to mee standards. 2) ALL OTHERS WITH POTENTIAL TO BE AFFECTIAL TO BE	the ting nd t set ED: f to NT ator ator re ary efire fire dill be

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	FOF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155251		A. BUILDING 01 B. WING		COMPLETED 05/25/2023	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD V 37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		HOBAF	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	COMPLETION DATE
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Sprinkler System -	- Maintenance and Testing - Maintenance and Testing - Maintenance and Testing er and standpipe systems			c) The Administrator will monitor adherence to the Fac Fire Plan/Fire Watch and valid the documentation is in place. 4) MONITORING CORRECTIVE ACTION: a) At least annually to ensure compliance, the Administrator Maintenance Supervisor/design will review the facilities fire place and make changes as necess to meet set standards. Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliant is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.	date . ure and gnee an eary e olans olans	
		er and standpipe systems ted, and maintained in					

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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

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155251	B. WING		05/25/2023	
WATERS	T	LLED NURSING FACILITY, THE	2901 V HOBAF	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		nd readily available. system last checked				
	b) Who provided	system test				
	c) Water system	supply source				
		-				
	failed to maintain the nurses station and nurses station and nurses trap hot air and and cause the sprind temperature. NFPA the distance betwee the ceiling above shappe of sprinkler and	on and interview, the facility the ceiling construction of 1 of 1 medicine rooms. The ceiling If gases around the sprinkler kler to operate at a specified 13, 2010 edition, 8.5.4.11 states on the sprinkler deflector and mall be selected based on the If the type of construction. If the ceiling the sprinkler deflector and mall deflects approximately 20	K 0353	K353 – It is the intent of the facility to ensure to maintain the ceiling construction of nurses stations and medicine rooms to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 5/26/23 the Maintenance Supervisor/design sealed the one-inch ceiling	nee	
	Findings include:			penetration with a one hour fire rated material in the suspended ceiling of the west end nurses		
	with the Maintenan Maintenance Assist 11:50 a.m. and 1:55 the west end nurses ceiling penetration ceiling. This condit of the sprinklers ins ceiling. Furthermor station also had a 1 on interview at the Maintenance Super	cons during a tour of the facility ce Supervisor and tent #1 on 05/25/23 between 5 p.m., in the suspended ceiling a station there was a 1 inch from cables running into the ion could delay the activation stalled on the suspended te, the Central Hall nurses inch gap in the ceiling Based time of the observations, the visor agreed there were ceiling bull need to be fixed.		station and in the Central Hall nurses station to meet set standards. The Administrator verified the work on 5/26/23. 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all staf and visitors have the potential to be affected but none were. 3.MEASURES TO PREVENT REOCCURRENCE: 1.On 6/9/23 the Administrator in-serviced the Maintenance Supervisor/design	f to	
	The finding was rev	viewed with the Maintenance		on the requirement that the cei		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 5/2023
	PROVIDER OR SUPPLIE S OF HOBART SKI	R LLED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP C V 37TH AVE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Assistant #1 and M the exit conference	laintenance Supervisor during		construction must be n with no penetrations to standards.		
	3.1-19(b)			2.Maintenance Supervisor/designee we the ceiling construction maintained with no per as a part of the facility' Maintenance Program document those inspersas appropriate. If any discovered, they will be and resolved immediate Maintenance Supervise will review with the Add the inspection results. 3.The Administrate monitor adherence to the Preventative Maintenance Supervise will review with the Add the inspection results. 3.The Administrate monitor adherence to the Preventative Maintenance Supervise M	n is netrations Is Preventive and ction results r issues are e addressed tely. The or/designee ministrator tor will the ince the ace. RRECTIVE results will laintenance to the and the een the ie monthly formance meeting. system viewed by with orrection nented as	
				compliance is maintair (Attachment F, F1, F2)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155251	B. WI			05/25/	
		100201			_	00/20/	2020
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
				2901 W	37TH AVE		
WATERS	OF HOBART SKI	LLED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					This plan of correction		
					constitutes our credible		
					allegation of compliance witl	n	
					all regulatory requirements.		
					Our date of compliance is		
					6/23/23.		
					0.20.20.		
K 0354	NFPA 101						
SS=F	Sprinkler System	- Out of Service					
Bldg. 01	Sprinkler System						
Biag. 01		ler system is impaired, the					
		on of the impairment has					
		, areas or buildings involved					
		d risks are determined,					
	•	•					
	recommendations						
	-	lesignated representative,					
		rtment and other authorities					
		n have been notified. Where					
		em is out of service for more					
		a 24-hour period, the					
	building or portior	n of the building affected are					
	evacuated or an a	approved fire watch is					
	provided until the	sprinkler system has been					
	returned to servic	e.					
	18.3.5.1, 19.3.5.1	, 9.7.5, 15.5.2 (NFPA 25)					
	Based on record re	view and interview, the facility	K 0.	354	K354- It is the intent of the fac	cility	06/23/2023
	failed to provide 1	of 1 correct written policies in			to ensure to provide correct w	ritten	
	the event the autom	natic sprinkler system has to be			policies in the event the autom		
		ce for 10 hours or more in a			sprinkler system has to be pla		
	-	accordance with LSC, Section			out of service for 10 hours or r		
	-	quires sprinkler impairment			in a 24 hour period in accorda		
		with NFPA 25, 2011 Edition,			with LSC, section 9.7.5 to mee		
		e Inspection, Testing and			set standards.		
		ater-Based Fire Protection			1) CORRECTIVE ACTIONS	<u>.</u>	
		5, 15.5.2 requires nine			TAKEN:		
	*	impairment coordinator shall			a) On 5/26/23 the		
	-	(b) states a fire watch should			Administrator/Maintenance		
	,					Votob	
	-	ersonnel who continuously			Supervisor updated the Fire W	valcn	
	-	area. Ready access to fire			policy to include: Contact the		
	extinguishers and t	he ability to promptly notify	1		Indiana Department of Health	via	

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	T OF HEALTH AND HUI R MEDICARE & MEDIC						IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01			COMPL	
THILD TETH	or conduction	155251	B. WIN		01	05/25/	
		100201	B. WIN			00/20/	72020
NAME OF	PROVIDER OR SUPPLIEF	3		STREET	ADDRESS, CITY, STATE, ZIP COD		
TOTAL OF	I KO VIDEK OK SOI I EIEI				V 37TH AVE		
WATER	S OF HOBART SKIL	LLED NURSING FACILITY, THE		HOBAF	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the fire department	are important items to			the IDOH Gateway link at		
	consider. During th	e patrol of the area, the person			https://gateway.isdh.in.gov as	the	
	should not only be	looking for fire, but making			primary method or by the		
	sure that the other f	are protection features of the			secondary method when the I	DOH	
	building such as eg	ress routes and alarm systems			Gateway is nonoperational by	,	
	are available and fu	nctioning properly. This			completing the Incident Repo		
	deficient practice co	ould affect all occupants in the			form and emailing it to	-	
	facility.				incidents@isdh.in.gov to mee	t set	
					standards.		
	Findings include:				2) ALL OTHERS WITH		
					POTENTIAL TO BE AFFECT	ED:	
	Based on records re	eview with the Maintenance			a) All residents and all staf	f	
	Supervisor on 05/2:	5/23 between 09:23 a.m. and			and visitors have the potentia	l to	
	11:42 a.m., the fire	watch plan failed to include			be affected but none were.		
	contacting the India	ana Department of Health via			3) MEASURES TO PREVE	NT	
	the IDOH Gateway				REOCCURRENCE:		
	https://gateway.isdl	h.in.gov as the primary method			a) Maintenance		
		method when the IDOH			Supervisor/designee will conta	act	
	Gateway is nonoper	rational by completing the			the authorities having jurisdict		
	Incident Reporting	form and e-mailing it to			the sprinkler system is out of		
		gov. Based on interview during			service for more than 10 hour	s in a	
		the Maintenance Supervisor			24-hour period per facility poli	CV	
		fire watch documentation			as a part of the facility's Preve	•	
		contact the IDOH but not via			Maintenance Program and		
		link or at the e-mail address			document those inspection re	sults	
	listed above.				as appropriate. If any issues		
					discovered, they will be addre		
	This finding was re	viewed with the Maintenance			and resolved immediately. The		
	_	aintenance Supervisor during			Maintenance Supervisor/design		
	the exit conference.	-			will review with the Administra	-	
					the inspection results.		
	3.1-19(b)				b) The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		

4) MONITORING **CORRECTIVE ACTION:**

The inspection results will

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 05/25/2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
				be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed 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 6/23/23.	ly e y
K 0511 SS=D Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 2 of witchen were secure personnel. NFPA 7 Energized parts of secure as specifies specified in 230.62	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 2, 91.1, 9.1.2 3, 91.1, 91.2 4, 91.1, 91.2 5, 91.1, 91.2 5, 91.1, 91.2 6, 91.1, 91.2 7, 91.1, 91.2 7, 91.1, 91.2 8, 91.2 8,	K 0511	K511 – It is the intent of the facility to ensure electrical pane in the kitchen are secured from non- authorized personnel to m set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 6/9/23 the Maintenance	neet

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so that they will not be exposed to accidental

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Supervisor/designee repaired the

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155251	B. WING 05/25/2023			2023	
			<u> </u>			<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\4/4.TED	0 0 1 1 0 D 1 D T 0 1 1	ULED NUIDONIO EAGULEY/ THE			/ 37TH AVE		
WATERS	OF HOBART SKI	LLED NURSING FACILITY, THE		HOBAH	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.12	DATE
	contact or shall be	guarded as in 230.62(B).			electrical panel locks in the		
	(B) Guarded. Ener	gized parts that are not enclosed			kitchen to meet set standards.		
		on a switchboard, panelboard, or			The Administrator verified the		
		guarded in accordance with			repairs on 6/9/23		
		. Where energized parts are			2. ALL OTHERS WITH		
		ed in 110.27(A)(1) and (A)(2), a			POTENTIAL TO BE AFFECTI	ED:	
		or sealing doors providing			a. All residents and all staf		
		d parts shall be provided. This			and visitors have the potential	-	
	1	could affect staff in the service			be affected but none were. O		
	hall.				6/9/23 the Maintenance		
					Supervisor/designee inspecte	d all	
	Findings include:				electrical panels in the kitcher		
					and found no other negative		
	Based on observat	ion with Maintenance			findings.		
		nintenance Assistant #1 on			3. MEASURES TO PREVE	NT	
	_	11:50 a.m. and 1:55 p.m., the			REOCCURRENCE:		
		the kitchen were unlocked and			a. On 6/9/23 the Administra	ator	
	_	Based on interview at the time			in-serviced the Maintenance	101	
	1 -	Maintenance Supervisor			Supervisor/designee on the		
		one panel was missing and the			requirement that electrical par	nels	
		ck when turned with a key.			in the kitchen must be locked		
					meet set standards.		
	Findings were disc	cussed with the Maintenance			b. Maintenance		
	_	nintenance Assistant #1 at exit			Supervisor/designee will inspe	ect	
	conference.	internation rissistant with at one			all kitchen panels monthly to	,01	
	Conference.				ensure they remain locked as	a	
	3.1-19(b)				part of the facility's Preventive		
	3.1 17(0)				Maintenance Program and	·	
					document those inspection re-	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/design		
					will review with the Administra	-	
					the inspection results.	i.oi	
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
	I		1		Preventative Maintenance	,	l

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155251	B. WI	B. WING		05/25/2023		
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	L			37TH AVE			
WATERS	S OF HOBART SKII	LED NURSING FACILITY, THE			RT, IN 46342			
	Г		1		,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					documentation is in place.			
					4. MONITORING			
					CORRECTIVE ACTION:			
					a. The inspection results w			
					be presented by the Maintena	nce		
					Supervisor/designee to the			
					Administrator monthly and the			
					Administrator will present the			
					inspection results at the month	•		
					Quality Assurance/Performand			
					Improvement (QA/PI) meeting			
					Inspection results and system			
					components will be reviewed I the QA/PI Committee with	Jy		
					subsequent plans of correction	2		
					developed and implemented a			
					deemed necessary to ensure	15		
					compliance is maintained.			
					(Attachment C)			
					This plan of correction			
					constitutes our credible			
					allegation of compliance with	า		
					all regulatory requirements.	•		
					Our date of compliance is			
					6/23/23.			
K 0521	NFPA 101							
SS=E	HVAC							
Bldg. 01	HVAC							
	Heating, ventilatio	n, and air conditioning shall						
	comply with 9.2 ar	nd shall be installed in						
	accordance with the	ne manufacturer's						
	specifications.							
	18.5.2.1, 19.5.2.1,							
		on and interview, the facility	K 0	521	K521 - It is the intent of the fac	cility	06/23/2023	
		f 7 egress corridors were not			to ensure egress corridors are	not		
	_	a return air system/plenum for			used as a portion of a return a	ir		
	heating, ventilating,	or air conditioning (HVAC)			system/plenum for heating,			
	ductwork serving ac	djoining areas. LSC 19.5.2.1			ventilating, or air conditioning			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY LETED 5/2023			
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 2901 W 37TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	ductwork and relate accordance with NF Installation of Air C Systems. NFPA 90 4.3.12.1.1 states egg as a portion of a supsystem serving adjopermitted by 4.3.12 deficient practice costaff and visitors on Findings include: Based on observation Supervisor during a a.m. to 1:55 p.m. or rooms and support 122 through 136 we a portion of a return interview at the tim Maintenance Super of the issue and an HVAC air to each requipped with an air This finding was re and the Maintenance conference. 3.1-19(b)	ons with the Maintenance tour of the facility from 11:50 in 05/25/23, resident sleeping offices 111 through 119 and ere using the egress corridor as a air system. Based on the observations, the visor stated they were aware operable HVAC unit supplies oom and each room is not		(HVAC) ductwork servareas to meet set star 1) CORRECTIVE A TAKEN: The facility respectfull the following plan of ca credible allegation of to the above-mentioned prefix K521. We have continuing waiver for following the factor of the facto	y submits orrection as of compliance ed regulation, applied for a financial attached			
K 0920 SS=D Bldg. 01	Extens Electrical Equipmone Extension Cords Power strips in a pused for compone	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment						

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPI B. WING 05/25					
		155251	B. WI	NG		05/25/	2023	
	NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			2901 W	ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE RT, IN 46342			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	assembled by qua the conditions of 1 the patient care vi	les that have been alified personnel and meet 10.2.3.6. Power strips in cinity 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							
		moved immediately upon						
		purpose for which it was ts the conditions of 10.2.4.						
		9), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5						
	Based on observation	on and interview, the facility	K 09	920	K920- It is the intent of the fac	ility	06/23/2023	
		f 1 power strips were not used			to ensure power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw to meet			
		xed wiring to provide power						
	equipment with a hi	-						
		0.8 state unless specifically						
	1 ^	flexible cords and cables shall			set standards.			
		as a substitute for fixed wiring.			1. CORRECTIVE ACTIONS			
	and an unknown am	ice could affect up to 2 staff			TAKEN: a. On 5/26/23 the Maintenance			
	and an unknown an	iount of residents.			a. On 5/26/23 the Maintena Supervisor/designee removed			
	Findings include:				power strip from the microwav meet set standards. The			
		ons during a tour of the facility			Administrator verified the remo	oval		
	with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between				of the cord on 5/26/23.			
					2. ALL OTHERS WITH			
		p.m., a microwave (high power			POTENTAL TO BE AFFECTE			
		as plugged into and supplied			a. All residents and all staff			
		trip. Based on interview at the			and visitors have the potential			
		, the Maintenance Supervisor			be affected but none were. Or	า		
	acknowledged power	er strips were supplying power			5/26/23 the Maintenance			

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	PROVIDER OR SUPPLIE S OF HOBART SKI	R LLED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	to high power draw plug the microwav observation.	requipment and was able to e in an outlet at the time of ussed with the Maintenance intenance Assistant #1 at exit		Supervisor/designee inspector rooms throughout the facility power strips and found no oth negative findings. 3. MEASURES TO PREVIOUS REOCCURRENCE: a. On 6/9/23 the Administrian-serviced the Maintenance Supervisor/designee and all estaff on the requirement that strips are not to be used as a substitute for fixed wiring to provide power equipment with high current draw in the facility meet set standards. b. Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly and remove any non-approved power strips for as a part of the facility's Prev Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with 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 we be presented by the Maintenance Supervisor/designee to the	ed all for ner ENT rator other power h a ty to ect ity ound entive esults s are essed he ignee ator

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPLE 05/25/2	ETED
	PROVIDER OR SUPPLIE	R LLED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
				Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. (Attachment D) This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.	hly ce g. i by n as	

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