STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155251	A. BUILDING -- B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	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	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: 05/25/23 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Emergency Preparedness survey, The Waters of Hobart Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 110 certified beds. At the time of the survey, the census was 42. Quality Review completed on 05/30/23	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jarrett Mitchell	Administrator	06/09/2023

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

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise 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, 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise 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 a 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or 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 a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] 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] annual exercise or and 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 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual 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; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE 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 years opposite the year the full-scale or functional exercise 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 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual 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. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, 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 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual 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; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	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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	years, opposite the year the full-scale or functional exercise 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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual 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. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional 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	E 0039	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of 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.** **E039** – It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least	06/23/2023

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that 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 LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Supervisor on 05/25/23 between 09:23 a.m. and 11:42 a.m., there was full documentation for the table top exercise conducted on 10/15/22 but documentation for a community or facility-based exercise was unavailable at the time of the survey. Based on interview at the time of records review, the Maintenance Supervisor stated a community or facility-based exercise could have been conducted, but documentation could not be found. During an interview later with the Administrator, he stated that the facility had switched over companies and documentation was lost in the process. Furthermore, the Administrator stated a power outage occurred, but only had an email for incident reporting. No after-action report or detailed summary had been documented. Findings were discussed with the Maintenance Supervisor and Maintenance Assistant #1 at exit conference.		twice per year, including unannounced staff drills using the emergency procedures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 6/9/23 the Administrator and the Maintenance Supervisor/designee conducted a community or facility-based exercise and completed documentation for the exercise 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 6/9/23 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that a community or facility-based exercise must be conducted annually and documentation retained to meet set standards. (Attachment G) b. Maintenance Supervisor/designee will work with the Administrator to ensure a community or facility-based exercise is conducted and documented to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c. The Administrator will monitor adherence to the Emergency Preparedness Policy	

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			Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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.**	
K 0000 Bldg. 01	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: 05/25/2023	K 0000		

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	Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Life Safety Code survey, The Waters of Hobart Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. A later one story addition, consisting of the east wing constructed prior to March 2003, determined to be Type V (111) was also fully sprinklered, therefore it was surveyed as one building in accordance with LSC Chapter 19. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. Battery powered smoke detectors are installed in all resident rooms. The building is partially protected by a 230 kW diesel powered emergency generator. The facility has the capacity for 110 and had a census of 42 at the time of this survey. Quality Review completed on 05/30/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are			

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	155251	A. BUILDING 01 B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 1. Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were 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 all approximately 15 staff and residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., the South 100 Hall corridor contained over 20 cardboard boxes. Based on an interview at the time of observations, the Maintenance Supervisor agreed there was a lot of storage in the corridor and stated a delivery came and they should have been unpacked and taken to designated areas. The findings were reviewed with the Maintenance Assistant #1 and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 7 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so	K 0211	**K211** – 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 and maintain exit discharge doors are free of impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 5/26/23 the Maintenance Supervisor/designee removed the cardboard boxes from the south 100 hall corridor to meet set standards. The Administrator verified the work on 5/26/23. b. On 5/26/23 the Maintenance Supervisor/designee repaired the exit door in the main dining area to meet set standards. The Administrator verified the work on 5/26/23. 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 5/26/23 the Maintenance Supervisor/designee inspected all corridors and exit doors and found no other negative findings. 3. **MEASURES TO PREVENT**	06/23/2023

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	that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect approximately 20 staff and residents near the Main Dining area. Findings include: Based on observations with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., the exit door in the Main Dining area was equipped with panic hardware, but the door would not open on the first try. It took the Maintenance Supervisor three tries to open the door and took excessive force to open the door on the fourth try. Based on interview at the time of observation, the Maintenance Supervisor agreed it took excessive force to open the exit door and was unaware of the issue The findings were reviewed with the Maintenance Assistant #1 and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**REOCCURRENCE**: a. On **6/9/23** the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement that the corridor means of egress are to remain free of obstructions and exit discharge doors are to remain free of impediments to full instant use to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions and will inspect all exit discharge doors for impediments 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. (Attachment A) 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	

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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 6/23/23.**	
K 0321 SS=E Bldg. 01	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 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	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 the corridor doors to 1 of 1 linen storage room which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect approximately 15 residents and staff.. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., the linen storage room, a hazardous storage room that was greater than 50 square feet, was equipped with self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Supervisor agreed the room was used as storage, was larger than 50 square feet, and stated the door latching mechanism would need to be replaced. Findings were discussed with the Maintenance Supervisor and Maintenance Assistant #1 at exit conference.	K 0321	**K321**– It is the intent of the facility to ensure the corridor door to hazardous area doors, such as storage room door, is provided with a self-closing device to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 5/26/23 the Maintenance Supervisor/designee replaced/repaired the self closing device on the linen storage room door so that it self closes and latches into the frame to meet set standards. The Administrator verified the work on 5/26/23 . **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 5/26/23 the Maintenance Supervisor/designee inspected all hazardous area doors for self closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 6/9/23 the Administrator	06/23/2023

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	3.1-19(b)		in-serviced the Maintenance Supervisor/designee/all staff on the requirement that all hazardous area doors must be protected with a self-closing device and self closes and latches into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure there is a self-closing device and it self closes and latches into the frame 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. (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 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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			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_____.**	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Supervisor on 05/25/23 between 09:23 a.m. and 11:42 a.m., the fire watch plan failed to include	K 0346	**K346**– It is the intent of the facility to ensure to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6 to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 5/26/23 the Administrator/Maintenance	06/23/2023

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	contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Supervisor acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Maintenance Assistant #1 and Maintenance Supervisor during the exit conference. 3.1-19(b)		Supervisor updated the fire watch plan to include contacting the Indiana Department of Health via the IDOH gateway link https://gateway.isdh.in.gov as the primary method or by the secondary method by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov 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 6/9/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the fire watch plan must include IDOH gateway link as primary method and email address as secondary method to meet set standards. b) Maintenance Supervisor/designee will ensure the IDOH gateway link is primary method and email address is secondary and included in the fire watch plan as a part of the facility's Emergency Preparedness Manual. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the results.	

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			c) The Administrator will monitor adherence to the Facilities Fire Plan/Fire Watch and validate the documentation is in place. 4) **MONITORING CORRECTIVE ACTION**: a) At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the facilities fire plan and make changes as necessary to meet set standards. Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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.**	
K 0353 SS=E Bldg. 01	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			

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	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 observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 nurses station and medicine rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects approximately 20 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., in the suspended ceiling the west end nurses station there was a 1 inch ceiling penetration from cables running into the ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Furthermore, the Central Hall nurses station also had a 1 inch gap in the ceiling Based on interview at the time of the observations, the Maintenance Supervisor agreed there were ceiling penetrations and would need to be fixed. The finding was reviewed with the Maintenance	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/designee sealed the one-inch ceiling penetration with a one hour fire rated material in the suspended ceiling of the west end nurses 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 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 6/9/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the ceiling	06/23/2023

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	Assistant #1 and Maintenance Supervisor during the exit conference. 3.1-19(b)		construction must be maintained with no penetrations to meet set standards. 2.Maintenance Supervisor/designee will ensure the ceiling construction is maintained with no penetrations 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. 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. (Attachment F, F1, F2)	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify	K 0354	**K354**– It is the intent of the facility to ensure to provide correct written policies in the event the automatic sprinkler system has to be placed out of service for 10 hours or more in a 24 hour period in accordance with LSC, section 9.7.5 to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 5/26/23 the Administrator/Maintenance Supervisor updated the Fire Watch policy to include: Contact the Indiana Department of Health via	06/23/2023

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	the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Supervisor on 05/25/23 between 09:23 a.m. and 11:42 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Supervisor acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Maintenance Assistant #1 and Maintenance Supervisor during the exit conference. 3.1-19(b)		the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov 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 contact the authorities having jurisdiction if the sprinkler system is out of service for more than 10 hours in a 24-hour period per facility policy 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	

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WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

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			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 6/23/23.**	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 electrical panel in the kitchen were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental	K 0511	**K511** – It is the intent of the facility to ensure electrical panels in the kitchen are secured from non- authorized personnel to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 6/9/23 the Maintenance Supervisor/designee repaired the	06/23/2023

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	contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the service hall. Findings include: Based on observation with Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., the electrical panels in the kitchen were unlocked and open when tested. Based on interview at the time of observation, the Maintenance Supervisor stated the latch of one panel was missing and the other would not lock when turned with a key. Findings were discussed with the Maintenance Supervisor and Maintenance Assistant #1 at exit conference. 3.1-19(b)		electrical panel locks in the kitchen to meet set standards. The Administrator verified the repairs on 6/9/23 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 6/9/23 the Maintenance Supervisor/designee inspected all electrical panels in the kitchen and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 6/9/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that electrical panels in the kitchen must be locked to meet set standards. b. Maintenance Supervisor/designee will inspect all kitchen panels monthly to ensure they remain locked 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	

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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. (Attachment C) **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.**	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 2 of 7 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1	K 0521	**K521** - It is the intent of the facility to ensure egress corridors are not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning	06/23/2023

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	requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect over 12 residents, staff and visitors on the east wing. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:50 a.m. to 1:55 p.m. on 05/25/23, resident sleeping rooms and support offices 111 through 119 and 122 through 136 were using the egress corridor as a portion of a return air system. Based on interview at the time of the observations, the Maintenance Supervisor stated they were aware of the issue and an operable HVAC unit supplies HVAC air to each room and each room is not equipped with an air return This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		(HVAC) ductwork serving adjoining areas to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: The facility respectfully submits the following plan of correction as a credible allegation of compliance to the above-mentioned regulation, prefix K521. We have applied for a continuing waiver for financial hardship. Please see attached documentation (Attachment E, E1,E2).	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips 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 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff and an unknown amount of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., a microwave (high power draw equipment) was plugged into and supplied power by a power strip. Based on interview at the time of observation, the Maintenance Supervisor acknowledged power strips were supplying power	K 0920	**K920**– It is the intent of the facility to ensure power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 5/26/23 the Maintenance Supervisor/designee removed the power strip from the microwave to meet set standards. The Administrator verified the removal of the cord on 5/26/23. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 5/26/23 the Maintenance	06/23/2023

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	to high power draw equipment and was able to plug the microwave in an outlet at the time of observation. Findings were discussed with the Maintenance Supervisor and Maintenance Assistant #1 at exit conference. 3.1-19(b)		Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 6/9/23 the Administrator in-serviced the Maintenance Supervisor/designee and all other staff on the requirement that power strips are not to be used as a substitute for fixed wiring to provide power equipment with a high current draw in the facility to meet set standards. b. Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly and remove any non-approved power strips found 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	

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			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. (Attachment D) **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.**	