STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155150	A. BUILDING -- B. WING	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

(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: 11/20/24 Facility Number: 000071 Provider Number: 155150 AIM Number: 100273140 At this Emergency Preparedness survey, Waters of Columbia City 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 a capacity of 84 and had a census of 26 at the time of this survey. Quality Review completed on 11/26/24	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:41 a.m., the facility provided two EPPs, one from the Administrators office and one from the nurses' station that contained conflicting policies. The EPP from the Administrator had policies for Millers Merry	E 0004	**E004** – It is the intent of the facility to ensure to review and update the Emergency Preparedness Plan at least annually in accordance with 42 CFR 483.73(a) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On or before 12/18/2024, the Administrator/DON/Maintenance Supervisor/designee updated the emergency preparedness program for The Waters of Columbia City and reviewed the plan with all staff	12/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie Barnes	Administrator	12/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155150	A. BUILDING -- B. WING	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

(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
	Manor mixed with The Waters policies and had no review date. The EPP from the nurses' station had The Waters policies, was reviewed in 2024, but some of the required information about the facility was left incomplete in the EPP's blank fields provided by the facility's company. Based on an interview during records review, the Maintenance Director agreed both policies had conflicting Policies and Procedures. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.		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 or before 12/18/2024, the Administrator inserviced the DON /Maintenance Supervisor on the requirement to update and review the emergency preparedness program annually to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program on or before 12/18/2024. b Maintenance Supervisor/DON/ designee will work with the Administrator to ensure the emergency preparedness program/plan is updated annually and reviewed 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 Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy	

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	155150	A. BUILDING -- B. WING	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

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			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 12/18/24.**	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:52 a.m., the paperwork	E 0006	**E006**– It is the intent of the facility to ensure to maintain an emergency preparedness plan that is based on and includes a documented, facility based and community-based risk assessment, utilizing an all hazards approach, including missing residents and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73 (a) (1) and 42 CFR 483.73(a) (2) to meet set standards.	12/18/2024

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	155150	A. BUILDING -- B. WING	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	provided regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach was not filled out. Based on an interview at the time of record review, the Maintenance Director agreed the risk assessment utilizing an all-hazards approach provided for review was left blank. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.		1 **CORRECTIVE ACTIONS TAKEN**: a On 12/10/24, the Maintenance Supervisor, DON and the Administrator updated the emergency preparedness plan that is based on and includes a documented, facility based and community based risk assessment, utilizing an all hazards approach which is reviewed annually and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73 (a) and 42 CFR 483.73(a) 2 to meet set standards. The Administrator verified the work on 12/10/24. 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 or before 12/18/24, the Administrator inserviced the Maintenance Supervisor/DON/designee and all staff on the requirement that the emergency preparedness plan must include a facility based and community-based risk assessment, utilizing an all hazards approached and reviewed annually to meet set standards. b The Maintenance Supervisor/DON/Administrator/designee will ensure the emergency	

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			preparedness plan must include a facility based and community-based risk assessment, utilizing an all hazards approached and reviewed annually to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator and Maintenance Supervisor/DON/designee will review the Emergency Preparedness Policy Manual 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 12/18/24.**	

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	155150	A. BUILDING -- B. WING	11/20/2024

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WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

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E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:41 a.m., the facility provided two EPPs, one from the Administrators office and one from the nurses' station that contained conflicting policies. The EPP from the Administrator had policies for Millers Merry Manor mixed with The Waters policies and had no review date. The EPP from the nurses' station had The Waters policies, was reviewed in 2024, but some of the required information about the facility was left incomplete in the EPP's blank fields provided by the facility's company. Based on an interview during records review, the Maintenance Director agreed both EPP Policies and Procedures had conflicting information. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.	E 0013	– It is the intent of the facility to ensure to review and update the emergency preparedness plan policies and procedures at least annually in accordance with 42 CFR 483.73(a) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 12/10/24, the Maintenance Supervisor/DON/Administrator reviewed and updated the policies and procedures in the emergency plan and updated it for the Waters of Columbia City 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 12/18/24, the Administrator in serviced the DON/ Maintenance Supervisor and all staff on the requirement to review and update the policies and procedures in the emergency plan annually to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program on 12/18/24. b The Administrator/Maintenance	12/18/2024

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			Supervisor/designee will ensure to review and update the policies and procedures in the emergency plans annually to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual to ensure it includes a letter from their natural gas provider 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 12/18/24.**	
E 0015 SS=F	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients			

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Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:02 a.m., the agreement for emergency fuel for the generator emergency power system was an agreement with United Oil made in 2017 with Millers Merry Manor and not with The Waters. Based on an interview at the time of record review, the Maintenance Director stated the generator emergency fuel agreement made in 2017 was with Millers Merry Manor and not with The Waters. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.	E 0015	**E015** – It is the intent of the facility to ensure emergency preparedness policies and procedures include at a minimum, (1) the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) food, water, medical, and pharmaceutical supplies (ii) alternate sources of energy to maintain – A. Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; B. Emergency lighting; C. Fire detection, extinguishing and alarm systems; and D. Sewage and waste disposal in accordance with 42 CFR 483.73 (b)(1) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 12/9/24, the Administrator and the Maintenance Supervisor/designee updated the policies and procedures for subsistence needs for residents and staff including the agreement for emergency fuel for the generator for the Waters of Columbia City to meet set standards. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to	12/18/2024

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			be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 12/18/24, the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement to ensure to update policies and procedures for subsistence needs for residents and staff including the agreement for emergency fuel for the generator for the Waters of Columbia City to meet set standards. b Maintenance Supervisor/designee will work with the Administrator to ensure to update policies and procedures for subsistence needs for residents and staff including the agreement for emergency fuel for the generator 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 Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards.	

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			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 12/18/24.**	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development and annual review of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents and reviewed and updated at least annually for LTC facilities in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all residents Findings include: Based on review of the facility's Emergency Preparedness Plan (EEP) with the Maintenance Director on 11/20/24 at 10:30 a.m., the mutual aid/transfer agreements with Parkview of Whitley,	E 0025	– It is the intent of the facility to ensure Emergency Preparedness Policies and Procedures include the development and annual review of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73 (b)(7) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 12/10/24, the Administrator and the DON/Maintenance	12/18/2024

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	Columbia City United Methodist Church, Happy Valley Skating Park, and Renaissance Village were not updated within the last year and were agreements made in 2017 with Millers Merry Manor and not with The Waters. Based on an interview during records review, the Maintenance Director stated the aforementioned arrangements with other facilities were not reviewed within the last year and the agreements were with Millers Merry Manor and not with The Waters. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.		Supervisor/designee reviewed and updated the mutual aid/transfer agreements with sister facilities and other providers to receive residents in the event of limitations or evacuations for The Waters of Columbia City 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 12/18/24, the Administrator inserviced the DON/Maintenance Supervisor/all staff on the requirement to ensure to update the communications plan in the emergency plan annually for the Waters of Columbia City to meet set standards. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to update the communications plan in the emergency plan 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 Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure	

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			compliance, the Administrator and DON/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 12/18/24.**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:41 a.m., the facility	E 0029	– It is the intent of the facility to ensure to review and update the Emergency Preparedness Plan Communication plan at least annually in accordance with 42 CFR 483.73 (a) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 12/18/24, the Administrator/DON/Maintenance	12/18/2024

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	provided two EPPs, one from the Administrators office and one from the nurses' station that contained conflicting policies. The EPP from the Administrator had policies for Millers Merry Manor mixed with The Waters policies and had no review date. The EPP from the nurses' station had The Waters policies, was reviewed in 2024, but some of the required information about the facility was left incomplete in the EPP's blank fields provided by the facility's company. Based on an interview during records review, the Maintenance Director agreed both EPP Communication plans had conflicting information. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.		Supervisor/designee updated the emergency preparedness program for The Waters of Columbia City to include the review and revision date and to ensure that all required information is completed and reviewed the plan with all staff 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 12/18/24, the Administrator inserviced the DON /Maintenance Supervisor and all staff on the requirement to update and review the emergency preparedness program annually including the review and revision date and to ensure that all required information is completed to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program on 12/18/24. b Maintenance Supervisor/DON/ designee will work with the Administrator to ensure the emergency preparedness program/plan is updated annually and reviewed to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c The Administrator will	

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WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

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			monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/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 12/18/24.**	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training program at least annually in accordance with 42 CFR 483.73(a).	E 0036	– It is the intent of the facility to ensure to review and update the Emergency Preparedness Plan (EPP) training program at least	12/18/2024

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	155150	A. BUILDING -- B. WING	11/20/2024

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	This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 10:41 a.m., the facility provided two EPPs, one from the Administrators office and one from the nurses' station that contained conflicting policies. The EPP from the Administrator had policies for Millers Merry Manor mixed with The Waters policies and had no review date. The EPP from the nurses' station had The Waters policies, was reviewed in 2024, but some of the required information about the facility was left incomplete in the EPP's blank fields provided by the facility's company. Based on an interview during records review, the Maintenance Director agreed both EPP Training program had conflicting information. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.		annually in accordance with 42 CFR 483.73(a) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On or before 12/18/24, the Administrator/DON/Maintenance Supervisor/designee updated the emergency preparedness program for The Waters of Columbia City to include the review and revision date and to ensure that all required information is completed and reviewed the plan with all staff 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 or before 12/18/24, the Administrator inserviced the DON /Maintenance Supervisor and all staff on the requirement to update and review the emergency preparedness program annually including the review and revision date and to ensure that all required information is completed to meet set standards. The Administrator inserviced all staff on the updated emergency preparedness program on or before 12/18/24. b Maintenance Supervisor/DON/ designee will work with the Administrator to ensure the emergency	

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			preparedness program/plan is updated annually and reviewed 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 Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/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 12/18/24.**	

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E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 11/20/24 at 11:00 a.m., there was documentation of a attendance sheet for EPP training on 06/22/24, but there was no documentation to show if staff could demonstrate knowledge of the EPP. Based on an interview at the time of records review, the Maintenance Director stated documentation for testing of staff knowledge on the EPP could not be found. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference.	E 0037	**E037** – It is the intent of the facility to ensure to conduct annual training for the Emergency Preparedness Program (EPP) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On or before 12/18/24, the Administrator and Maintenance Supervisor/DON/designee completed an inservice sheet with the documentation and staff acknowledgment to demonstrate knowledge of the EPP training 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 or before 12/18/24, the Administrator inserviced the DON/ Maintenance Supervisor/All department heads / designee on the requirement to ensure all staff demonstrate knowledge of the EPP trainings to meet set standards. b DON/Maintenance Supervisor/ All department heads / designee will work with the Administrator to ensure all staff demonstrate knowledge of the EPP trainings to meet set standards. If any issues are	12/18/2024

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			discovered, they will be addressed and resolved immediately. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/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 12/18/24.**	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/20/24 Facility Number: 000071 Provider Number: 155150 AIM Number: 100273140 At this LSC survey, Waters of Columbia City Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 84 and had a census of 26 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered. Quality Review completed on 11/26/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of 6 storerooms rooms greater	K 0321	– It is the intent of the facility to ensure storeroom rooms greater	12/18/2024

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	than 50 square feet and being used for storage of large amounts of combustibles were protected as a hazardous area. This deficient practice could affect staff on the lower level. Findings include: Based on observations with the Maintenance Director on 11/20/24 at 12:45 p.m., rooms 23 and 25 on the lower level contained over 25 boxes of supplies, 20 plastic PPE carts, were greater than 50 square feet, therefore making the rooms hazardous areas. The two rooms were not protected as hazardous areas because the corridor doors to the rooms were not self-closing or automatic closing. Based on an interview at the time of observation, the Maintenance Director agreed the two rooms contained large amounts of combustible storage, were larger than 50 square feet, and the corridor doors to the rooms were not self-closing. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		than 50 square feet and being used for storage of large amounts of combustibles are protected as a hazardous area to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On or before 12/18/24, the Maintenance Supervisor/designee added door closures to rooms 23 and 25 to ensure door self closes and latches to meet set standards. The Administrator verified the work on 12/18/24 . **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 or before 12/18/24, the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement to ensure hazardous areas are equipped with a self-closing door to meet set standards. b Maintenance Supervisor/designee will ensure hazardous areas are equipped with a self-closing door as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator	

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			the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 2 of 4 sprinklers in the cooking room in the kitchen were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and	K 0353	– It is the intent of the facility to ensure sprinklers in the cooking room in the kitchen are free of corrosion to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**:	12/18/2024

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	shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff on the bottom story. Findings include: Based on observation with the Maintenance Director on 11/20/24 at 12:30 p.m., the two-sprinkler heads in the kitchen by the stoves were green and showed signs of corrosion. Based on an interview at the time of observation, the Maintenance Director agreed two sprinkler heads in the kitchen showed signs of corrosion. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		1.On 12/10/24, facilities licensed sprinkler contractor replaced the two sprinkler heads in the kitchen by the stoves to meet set standards. The Administrator verified the work on 12/10/24. **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 or before 12/18/24, the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure sprinkler in the cooking room in the kitchen are free of corrosion to meet set standards. 2.Maintenance Supervisor/designee will ensure sprinkler in the cooking room in the kitchen are free of corrosion 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.	

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			4.MONITORING CORRECTIVE ACTION: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.**	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on records review and interview, the facility failed to ensure 1 of 1 K-class portable fire extinguishers were repaired or replaced when the pressure gauge reading or indicator was not in the operable range or position. NFPA 10 Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for	K 0355	– It is the intent of the facility to ensure K class portable fire extinguishers are repaired or replaced when the pressure gauge reading or indicator is not in the operable range or position to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 12/10/24, the Administrator/Maintenance Supervisor/designee replaced the K class fire extinguisher located in	12/18/2024

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	selfexpelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators Section 7.2.3 Corrective Action states when an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. This deficient practice affects staff in the kitchen. Findings include: Based on observation with the Maintenance Director on 11/20/24 at 12:32 p.m., the gauge on the K-class fire extinguisher in the kitchen showed the pressure gauge out of range due to high pressure. Based on an interview during records review, the Maintenance Director stated the extinguisher was overcharged and needed replaced. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		the kitchen to meet set standards. The Administrator verified the relocation on 12/10/24 . **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 or before 12/18/24, the Administrator inserviced the Maintenance Supervisor/and all dietary staff on the requirement that portable fire extinguishers must be repaired or replaced when pressure gauge reading or indicator is not in operable range or position to meet set standards. b Maintenance Supervisor/designee will ensure portable fire extinguishers are repaired or replaced when pressure gauge reading or indicator is not in operable range or position as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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			Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance 12/18/24.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 2 electrical outlets in the satellite kitchen contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This	K 0511	– It is the intent of the facility to ensure electrical outlets in the satellite kitchen contained a cover plate and was protected from damage to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 12/10/24, the Maintenance Supervisor/designee installed a cover plate on the electrical outlet in the satellite	12/18/2024

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	deficient practice could affect 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 11/20/24 at 12:10 p.m., in the satellite kitchen there was an electrical outlet missing the cover plate exposing metal terminals. Based on an interview at the time of observation, the Maintenance Director agreed the outlet was missing a cover plate and there were electrical contacts visible. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		kitchen to meet set standards. The Administrator verified the work on 12/10/24 . 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 or before 12/18/24, the Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure electrical wiring is protected to include electrical outlet inspection to meet set standards. b Maintenance Supervisor/designee will ensure electrical wiring is protected to include electrical outlet inspection as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will	

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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 12/18/24.**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords and 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw or met the UL rating of 1363A or 60601-1 in patient care locations according to LSC/2012 chapter 19 and NFPA-70/2011, 400.8. This deficient practice could affect 4 residents. Findings include: Based on observations with the Maintenance Director on 11/20/24 at 11:52 a.m., the following areas had improper use of power strips and extension cords: A.) In room 15 an extension cord was used to	K 0920	It is the intent of the facility to ensure extension cords including power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw or met the UL rating of 1363A or 60601-1 in patient care area locations according to LSC/2012 chapter 19 and NFPA 70/2011, 400.8 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11/20/24, the Maintenance Supervisor/designee removed the extension cord from	12/18/2024

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	155150	A. BUILDING 01 B. WING	11/20/2024

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	power a resident's lamp. B.) In room 8 and 15 a power-strip that did not meet 1363A or 60601-1 was used to power the resident's electronics. Based on interview at the time of observation, the Maintenance Director Agreed an extension cord and power-strips not meeting 1363A or 60601-1 were being used in a patient care area. This finding was reviewed with the Director of Nursing and Maintenance Director during the exit conference. 3.1-19(b)		room 15 to meet set standards. The Administrator verified the removal on 11/21/24. 2.On 11/20/24, the Maintenance Supervisor/designee removed the power strips from room 7 & 15 to meet set standards. The Administrator verified the removal on 11/21/24. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 11/20/24, the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and extension cords and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On or before 12/18/24, the Administrator inserviced the Maintenance Supervisor/designee/all other staff that power strips and extension cords are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips or extension cords in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they	

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			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. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is 12/18/24.** **Requesting paper compliance.**	