PRINTED: 12/13/2024

							RM APPROVED IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIE	R CITY SKILLED NURSING FACILIT	Υ	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000								
Bldg		eparedness Survey was ndiana Department of Health in 2 CFR 483.73.	E 0	000				
	Survey Date: 11/2 Facility Number: (Provider Number:	000071 155150						
	of Columbia City found not in comp Preparedness Requ Medicaid Participa CFR 483.73. The had a census of 26	Preparedness survey, Waters Skilled Nursing Facility was liance with Emergency airements for Medicare and ating Providers and Suppliers, 42 facility has a capacity of 84 and at the time of this survey.						
E 0004 SS=C Bldg	403.748(a), 416. Develop EP Plan Annually	54(a), 418.113(a), 441.1 Review and Update eview and interview, the facility	E 0	004	E004 . It is the intent of the fr	acility	12/19/2024	
	failed to review an Preparedness Plan	d update the Emergency (EPP) at least annually in 2 CFR 483.73(a). This deficient	E 0	υU 4	E004 – It is the intent of the fato ensure to review and update Emergency Preparedness Plateast annually in accordance of 42 CFR 483.73(a) to meet sets standards. 1 CORRECTIVE ACTIONS TAKEN:	te the an at with t	12/18/2024	

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

Based on records review with the Maintenance

Director on 11/20/24 at 10:41 a.m., the facility

office and one from the nurses' station that

provided two EPPs, one from the Administrators

contained conflicting policies. The EPP from the

Administrator had policies for Millers Merry

On or before 12/18/2024, the

Administrator/DON/Maintenance

Supervisor/designee updated the

for The Waters of Columbia City

TITLE

emergency preparedness program

and reviewed the plan with all staff

(X6) DATE

Laurie Barnes Administrator 12/12/2024

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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	TRUCTION (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING		COMPLETED	
		155150	B. WING	·		11/20/	2024
		•		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEI	₹	6	640 W E	ELLSWORTH ST		
WATERS	OF COLUMBIA C	ITY SKILLED NURSING FACILITY	Y (COLUM	IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	7	ΓAG	DEFICIENCY)		DATE
		The Waters policies and had no			to meet set standards.		
		PP from the nurses' station had			2 ALL OTHERS WITH		
	_	s, was reviewed in 2024, but			POTENTIAL TO BE AFFECTE		
	_	d information about the facility			a All residents and all staff		
	_	in the EPP's blank fields			and visitors have the potential	to	
	-	ility's company. Based on an			be affected but none were.	NIT	
	_	cords review, the Maintenance			3 MEASURES TO PREVE	NI	
	_	th policies had conflicting			REOCCURRENCE:		
	Policies and Proced	iures.			a On or before 12/18/2024		
	This finding was to	viewed with the Director of			Administrator inserviced the D /Maintenance Supervisor on the		
		enance Director during the exit			requirement to update and rev		
	conference.	chance Director during the exit			the emergency preparedness	IEW	
	conference.				program annually to meet set		
					standards. The Administrator		
					inserviced all staff on the upda	ated	
					emergency preparedness pro		
					on or before 12/18/2024.	gram	
					b Maintenance		
					Supervisor/DON/ designee wil	I	
					work with the Administrator to		
					ensure the emergency		
					preparedness program/plan is	;	
					updated annually and reviewe		
					meet set standards. If any		
					issues are discovered, they w	ill be	
					addressed and resolved		
					immediately.		
					c The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a At least annually to ensu		
					compliance, the Administrator	and	
					DON/Maintenance		
					Supervisor/designee will revie		
					Emergency Preparedness Pol	icy	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 V	FADDRESS, CITY, STATE, ZIP COD VELLSWORTH ST IMBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0006 SS=F		416.54(a)(1)-(2), 418		Manual and conduct required exercises and make changes necessary to meet set standa Those reviews will be docume as appropriate. The Administr will present the training result the Quality Assurance/ Performance Improvement (Comeeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.	rds. ented ator s at A/PI) by n as
Bldg	Based on record reversal failed to maintain and Plan (EPP) that was documented, facility risk assessment, util including missing restrategies for address identified by the risk with 42 CFR 483.73. This deficient practice. Findings include: Based on records response to maintain and process to the records response to	Hazards Risk Assessment liew and interview, the facility in Emergency Preparedness (1) based on and includes a y-based and community-based lizing an all-hazards approach, esidents and (2) included sing emergency events k assessment in accordance B(a) (1) and 42 CFR 483.73(a) (2). Ice could affect all occupants. View with the Maintenance 4 at 10:52 a.m., the paperwork	E 0006	E006— It is the intent of the facto ensure to maintain an emergency preparedness platis based on and includes a documented, facility based art community-based risk assessment, utilizing an all hazards approach, including missing residents and include strategies for addressing emergency events identified by risk assessment in accordance with 42 CFR 483.73 (a) (1) art CFR 483.73(a) (2) to meet se standards.	n that d y the e nd 42

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED
		155150	B. W	NG		11/20	/2024
		•		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIEI	R		640 W I	ELLSWORTH ST		
WATERS	OF COLUMBIA C	ITY SKILLED NURSING FACILITY		COLUM	MBIA CITY, IN 46725		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		a documented facility-based sed risk assessment utilizing an			1 CORRECTIVE ACTIONS TAKEN:	5	
	1	ch was not filled out. Based on					
		time of record review, the			a On 12/10/24, the Maintenance Supervisor, DOI	N and	
	Maintenance Director agreed the risk assessment				the Administrator updated the		
		ards approach provided for			emergency preparedness plai		
	review was left blan				is based on and includes a	Titlat	
					documented, facility based an	ıd	
	This finding was re	eviewed with the Director of			community based risk		
		enance Director during the exit			assessment, utilizing an all		
	conference.				hazards approach which is		
					reviewed annually and include	ed	
					strategies for addressing		
					emergency events identified b	y the	
					risk assessment in accordance		
					with 42 CFR 483.73 (a) and 4		
					CFR 483.73(a) 2 to meet set		
					standards. The Administrato		
					verified the work on 12/10/24.		
					2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECT		
					a All residents and all staf		
					and visitors have the potential be affected but none were.	1 10	
					3 MEASURES TO PREVE	:NT	
					REOCCURRENCE:	4 1	
					a On or before 12/18/24, t	he	
					Administrator inserviced the	=	
					Maintenance		
					Supervisor/DON/designee and	d all	
					staff on the requirement that t	he	
					emergency preparedness pla	n	
					must include a facility based a	and	
					community-based risk		
					assessment, utilizing an all		
					hazards approached and revi		
					annually to meet set standard	S.	
					b The Maintenance		
					Supervisor/DON/Administrato		
	ī		1		I iange will encure the emerger	101/	1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	A. BUILDING COM		COMPLI	DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 W I	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST IBIA CITY, IN 46725			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
				preparedness plan must include facility based and community-based risk assessment, utilizing an all hazards approached and revie annually to meet set standards of the Administrator will monitor adherence to the Emergency Preparedness Pol 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 at make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator present the training results at Quality Assurance/ Performant Improvement (QA/PI) meeting Results and system component will be reviewed by the QA/PI Committee with subsequent profice for correction developed and implemented as deemed necessary to ensure compliancies is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.	ewed s		

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12/13/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/20/2024 155150 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 640 W ELLSWORTH ST WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY COLUMBIA CITY, IN 46725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE E 0013 403.748(b), 416.54(b), 418.113(b), 441.1 SS=C Development of EP Policies and Procedures Bldg. --Based on record review and interview, the facility E 0013 - It is the intent of the facility to 12/18/2024 failed to review and update the Emergency ensure to review and update the Preparedness Plan (EPP) Policies and Procedures emergency preparedness plan at least annually in accordance with 42 CFR policies and procedures at least 483.73(a). This deficient practice could affect all annually in accordance with 42 occupants. CFR 483.73(a) to meet set standards. Findings include: **CORRECTIVE ACTIONS** TAKEN: Based on records review with the Maintenance On 12/10/24, the Director on 11/20/24 at 10:41 a.m., the facility Maintenance provided two EPPs, one from the Administrators Supervisor/DON/Administrator office and one from the nurses' station that reviewed and updated the policies contained conflicting policies. The EPP from the and procedures in the emergency Administrator had policies for Millers Merry plan and updated it for the Waters Manor mixed with The Waters policies and had no of Columbia City to meet set review date. The EPP from the nurses' station had standards. The Waters policies, was reviewed in 2024, but **ALL OTHERS WITH** 2 some of the required information about the facility POTENTIAL TO BE AFFECTED: was left incomplete in the EPP's blank fields All residents and all staff provided by the facility's company. Based on an and visitors have the potential to interview during records review, the Maintenance be affected but none were. Director agreed both EPP Policies and Procedures **MEASURES TO PREVENT** had conflicting information. REOCCURRENCE: On 12/18/24, the This finding was reviewed with the Director of Administrator in serviced the DON/ Nursing and Maintenance Director during the exit Maintenance Supervisor and all conference. 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

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Event ID:

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12/18/24.

The

Administrator/Maintenance

b

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES ON							B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155150	B. W	ING		11/20/2024	
				STREET.			
NAME OF F	PROVIDER OR SUPPLIEF	8			ELLSWORTH ST		
WATERS	OF COLUMBIA C	ITY SKILLED NURSING FACILITY			MBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Supervisor/designee will ensu	re 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 Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The Administrator and		
					Maintenance Supervisor/desig	gnee	
					will review the Emergency		
					Preparedness Policy Manual t		
					ensure it includes a letter from		
					their natural gas provider to m		
					set standards. Those reviews		
					be documented as appropriate		
					The Administrator will present	the	
					training results at the Quality		
					Assurance/ Performance		
					Improvement (QA/PI) meeting		
					Results and system componer	nts	
					will be reviewed by the QA/PI	l	
					Committee with subsequent p	ians	
					of correction developed and		
					implemented as deemed		
					necessary to ensure complian is maintained.	ce	
					This plan of correction constitutes our credible		
						h	
					all regulatory requirements	11	
					all regulatory requirements. Our date of compliance is		
					12/18/24		

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403.748(b)(1), 418.113(b)(6)(iii), 441.1

Subsistence Needs for Staff and Patients

E 0015

SS=F

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	III TIDI E C	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ	JILDING	ONSTRUCTION	COMPI	
ANDILAN	OF CORRECTION	155150	B. W			11/20	
		133130	D. W.	_		11/20	72024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	ine (ibbit en seil bil				ELLSWORTH ST		
WATERS	S OF COLUMBIA C	CITY SKILLED NURSING FACILIT	ΓΥ	COLUI	MBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
Bldg							
	Based on record re	view and interview, the facility	E 00	015			12/18/2024
	failed to ensure em	ergency preparedness policies			E015 – It is the intent of the		
	and procedures inc	lude at a minimum, (1) The			facility to ensure emergency		
	provision of subsis	tence needs for staff and			preparedness policies and		
	residents, whether	they evacuate or shelter in			procedures include at a minim	ium,	
	place, include, but	are not limited to the following:			(1) the provision of subsistence	е	
	(i) Food, water, me	edical, and pharmaceutical			needs for staff and residents,		
	supplies. (ii) Alternate sources of energy to				whether they evacuate or she	lter	
	maintain - (A) Temperatures to protect resident			in place, include, but are not			
	health and safety and for the safe and sanitary			limited to the following: (i) food,		d,	
	storage of provision	ns; (B) Emergency lighting; (C)		water, medical, and			
	Fire detection, exti	nguishing, and alarm systems;		pharmaceutical supplies (ii)			
	and (D) Sewage an	d waste disposal in accordance			alternate sources of energy to	ı	
	with 42 CFR 483.7	(3(b)(1). This deficient practice			maintain – A. Temperatures to)	
	could affect all occ	cupants.			protect resident health and sa	fety	
					and for the safe and sanitary		
	Findings include:				storage of provisions; B.		
					Emergency lighting; C. Fire		
	Based on records re	eview with the Maintenance			detection, extinguishing and a	larm	
	Director on 11/20/2	24 at 10:02 a.m., the agreement			systems; and D. Sewage and		
	for emergency fuel	for the generator emergency			waste disposal in accordance	with	
	power system was	an agreement with United Oil			42 CFR 483.73 (b)(1) to meet	set	
	made in 2017 with	Millers Merry Manor and not			standards.		
	with The Waters.	Based on an interview at the			1 CORRECTIVE ACTIONS	3	
	time of record revi	ew, the Maintenance Director			TAKEN:		
	stated the generator	r emergency fuel agreement			a On 12/9/24, the		
	made in 2017 was	with Millers Merry Manor and			Administrator and the		
	not with The Water	rs.			Maintenance Supervisor/design	gnee	
					updated the policies and		
	This finding was re	eviewed with the Director of			procedures for subsistence ne	eeds	
	Nursing and Maint	enance Director during the exit			for residents and staff including	ıg	
	conference.				the agreement for emergency	fuel	
					for the generator for the Wate	rs of	
					Columbia City to meet set		
					standards.		

ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff and visitors have the potential to

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024
	ROVIDER OR SUPPLIER	ITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				be affected but none were. 3 MEASURES TO PREVERECCURRENCE: a On 12/18/24, the Administrator inserviced the Maintenance Supervisor/desi and all staff on the requireme ensure to update policies and procedures for subsistence in for residents and staff including the agreement for emergency for the generator for the Wate Columbia City to meet set standards. b Maintenance Supervisor/designee will work the Administrator to ensure to update policies and procedur subsistence needs for resider and staff including the agreer for emergency fuel for the generator to meet set standar If any issues are discovered, will be addressed and resolve immediately. c The Administrator will monitor adherence to the Emergency Preparedness Po Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a At least annually to ens compliance, the Administrato DON/Maintenance Supervisor/designee will revie Emergency Preparedness Po Manual and conduct required exercises and make changes necessary to meet set standar	gnee Int to It leeds Ing It fuel Iters of Iters

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY		640 W E	DDRESS, CITY, STATE, ZIP COD ELLSWORTH ST IBIA CITY, IN 46725		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0025 SS=F Bldg	403.748(b)(7), 418 Arrangement with	3.113(b)(5), 441.184(b) Other Facilities			Those reviews will be docume as appropriate. The Administra will present the training results the Quality Assurance/ Performance Improvement (Queeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.	ator s at A/PI) Dy n ss	
	failed to ensure eme and procedures incl annual review of an facilities and other p in the event of limit operations to mainta to LTC residents an least annually for L' 42 CFR 483.73(b)(7 affect all residents Findings include: Based on review of Preparedness Plan (Director on 11/20/2	riew and interview, the facility orgency preparedness policies ude the development and rangements with other LTC providers to receive residents ations or cessation of ain the continuity of services d reviewed and updated at TC facilities in accordance with 7). This deficient practice could the facility's Emergency EEP) with the Maintenance 4 at 10:30 a.m., the mutual cents with Parkview of Whitley.	E 002	25	- It is the intent of the facility to ensure Emergency Preparedn Policies and Procedures include the development and annual most arrangements with other LT facilities and other providers to receive residents in the event limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 4 CFR 483.73 (b)(7) to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 12/10/24, the Administrator and the DON/Maintenance	ess de eview C o of	12/18/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED	
		155150	B. WI	NG		11/20/	/2024
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\\\\ TED 6	05 001 114514 01	T. (0 () ED A ED A			ELLSWORTH ST		
WATERS	S OF COLUMBIA CI	ITY SKILLED NURSING FACILITY		COLUM	IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Columbia City Unit	ted Methodist Church, Happy			Supervisor/designee reviewed	and	
	Valley Skating Park	x, and Renaissance Village were			updated the mutual aid/transfe		
	not updated within	the last year and were			agreements with sister facilitie	s	
	agreements made in	2017 with Millers Merry			and other providers to receive		
	Manor and not with	The Waters. Based on an			residents in the event of limita	tions	
	interview during red	cords review, the Maintenance			or evacuations for The Waters	of	
	Director stated the a	aforementioned arrangements			Columbia City to meet set		
	with other facilities	were not reviewed within the			standards.		
	last year and the ag	reements were with Millers			2 ALL OTHERS WITH		
	Merry Manor and n	ot with The Waters.			POTENTIAL TO BE AFFECTE	ED:	
					a All residents and all staff	:	
	This finding was re	viewed with the Director of			and visitors have the potential	to	
	Nursing and Mainte	enance Director during the exit			be affected but none were.		
	conference.				3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a On 12/18/24, the		
					Administrator inserviced the		
					DON/Maintenance Supervisor	/all	
					staff on the requirement to ens	sure	
					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 pl		
					in the emergency plan to mee	t set	
					standards. If any issues are		
					discovered, they will be addre	ssed	
					and resolved immediately.		
					c The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		

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At least annually to ensure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETER					
		155150	B. WING	G		11/20/2024	
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY		640 W E	DDRESS, CITY, STATE, ZIP COD ELLSWORTH ST BIA CITY, IN 46725		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	compliance, the Administrator DON/Maintenance Supervisor/designee will revieve Emergency Preparedness Pol Manual and conduct required exercises and make changes and necessary to meet set standar Those reviews will be docume as appropriate. The Administra will present the training results the Quality Assurance/Performance Improvement (Quality Assurance) Results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.	w the icy as ds. nted ator at A/PI)	DATE
E 0029 SS=C Bldg	` '	4(c), 418.113(c), 441.1 ommunication Plan					
	failed to review and Preparedness Plan (least annually in acc 483.73(a). This defi occupants. Findings include: Based on records re	view and interview, the facility l update the Emergency EPP) Communication plan at cordance with 42 CFR cient practice could affect all view with the Maintenance 4 at 10:41 a.m., the facility	E 002	29	 It is the intent of the facility to ensure to review and update the Emergency Preparedness Plate Communication plan at least annually in accordance with 42 CFR 483.73 (a) to meet set standards. CORRECTIVE ACTIONS TAKEN: a On 12/18/24, the Administrator/DON/Maintenan 	ne n <u>2</u>	12/18/2024

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024
	PROVIDER OR SUPPLIEI	R ITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
TAG	provided two EPPs office and one from contained conflictin Administrator had a Manor mixed with review date. The El The Waters policies some of the require was left incomplete provided by the fact interview during re Director agreed both had conflicting info	o, one from the Administrators in the nurses' station that ing policies. The EPP from the policies for Millers Merry The Waters policies and had no PP from the nurses' station had is, was reviewed in 2024, but d information about the facility in the EPP's blank fields ility's company. Based on an cords review, the Maintenance the EPP Communication plans	TAG	Supervisor/designee updated emergency preparedness profor The Waters of Columbia Conclude the review and revision date and to ensure that all required information is compliand reviewed the plan with all to meet set standards. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECT and I residents and all standard visitors have the potential be affected but none were. 3 MEASURES TO PREVIOUS REOCCURRENCE: a On 12/18/24, the Administrator inserviced the Information is compliant review the emergency preparedness program annual including the review and revisit date and to ensure that all required information is compliate and to ensure that all required information is compliate and to ensure that all required information is compliate and to ensure that all required information is compliate and to ensure that all required information is compliate and to ensure that all required information is compliate and to ensure that all required information is compliated and the emergency preparedness program on 12/18/24. b Maintenance Supervisor/DON/ designee we work with the Administrator to ensure the emergency preparedness program/plan is updated annually and review meet set standards. If any issues are discovered, they waddressed and resolved immediately. C. The Administrator will	I the ogram City to on eted I staff ED: ff all to ENT CON I all odate ally sion eted taff eted taff ill o sed to

	of correction X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (2)	3) DATE SURVEY COMPLETED 11/20/2024
	PROVIDER OR SUPPLIER S OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA 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 0036	403.748(d), 416.54(d), 418.113(d), 441.1		monitor adherence to the Emergency Preparedness Polici 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 Emergency Preparedness Polici Manual and conduct required exercises and make changes as necessary to meet set standard. Those reviews will be document as appropriate. The Administrati will present the training results at the Quality Assurance/ Performance Improvement (QAmeeting. 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.	end the y s s s. ted or at (PI)
SS=C Bldg	EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency	E 0036	- It is the intent of the facility to ensure to review and update the	12/18/2024
	Preparedness Plan (EPP) Training program at least annually in accordance with 42 CFR 483.73(a).		Emergency Preparedness Plan (EPP) training program at least	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024		
		ROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR This deficient pract Findings include: Based on records re Director on 11/20/2 provided two EPPs, office and one from contained conflictin Administrator had p Manor mixed with	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ice could affect all occupants. Eview with the Maintenance 4 at 10:41 a.m., the facility one from the Administrators the nurses' station that ag policies. The EPP from the policies for Millers Merry The Waters policies and had no PP from the nurses' station had	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) annually in accordance with 4 CFR 483.73(a) to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On or before 12/18/24, t Administrator/DON/Maintenar Supervisor/designee updated emergency preparedness pro- for The Waters of Columbia C include the review and revisio date and to ensure that all	DATE 2 S the nce the gram city to
		The Waters policies some of the required was left incomplete provided by the fact interview during red Director agreed both conflicting information. This finding was re-	s, was reviewed in 2024, but d information about the facility in the EPP's blank fields ility's company. Based on an cords review, the Maintenance th EPP Training program had		required information is completed and reviewed the plan with all to meet set standards. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTION a All residents and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVERECCURRENCE: a On or before 12/18/24, the Administrator inserviced the Element of the Maintenance Supervisor and	ED: If Ito Interpretation
					staff on the requirement to up and review the emergency preparedness program annual including the review and revision date and to ensure that all required information is completed to meet set standards. The Administrator inserviced all states 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	date illy ion eted aff

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2024
	ROVIDER OR SUPPLIES	R ITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION DATE
				preparedness program/plan updated annually and review meet set standards. If any issues are discovered, they addressed and resolved immediately. c The Administrator will monitor adherence to the Emergency Preparedness F Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a At least annually to encompliance, the Administrated DON/Maintenance Supervisor/designee will reverence Emergency Preparedness F Manual and conduct required exercises and make changed necessary to meet set standard Those reviews will be docurn as appropriate. The Administrated will present the training resurt the Quality Assurance/Performance Improvement meeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance was all regulatory requirements. Our date of compliance is 12/18/24.	wed to will be Policy Insure Iter and View the Policy Iter dec as Iter dec a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/20/2024 155150 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 640 W ELLSWORTH ST WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY COLUMBIA CITY, IN 46725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE E 0037 403.748(d)(1), 416.54(d)(1), 418.113(d)(SS=C **EP Training Program** Bldg. --Based on record review and interview, the facility E 0037 **E037** – It is the intent of the facility 12/18/2024 failed to conduct annual training for the to ensure to conduct annual Emergency Preparedness Program (EPP). The LTC training for the Emergency facility must do all of the following: (i) Initial Preparedness Program (EPP) to training in emergency preparedness policies and meet set standards. procedures to all new and existing staff, **CORRECTIVE ACTIONS** individuals providing services under arrangement, TAKEN: and volunteers, consistent with their expected On or before 12/18/24, the roles; (ii) Provide emergency preparedness Administrator and Maintenance Supervisor/DON/designee training at least annually; (iii) Maintain documentation of all emergency preparedness completed an inservice sheet with training; (iv) Demonstrate staff knowledge of the documentation and staff emergency procedures in accordance with 42 CFR acknowledgment to demonstrate 483.73(d) (1). This deficient practice could affect knowledge of the EPP training to all residents in the facility. meet set standards. **ALL OTHERS WITH** Findings include: POTENTIAL TO BE AFFECTED: All residents and all staff Based on records review with the Maintenance and visitors have the potential to Director on 11/20/24 at 11:00 a.m., there was be affected but none were. documentation of a attendance sheet for EPP **MEASURES TO PREVENT** training on 06/22/24, but there was no REOCCURRENCE: documentation to show if staff could demonstrate On or before 12/18/24, the knowledge of the EPP. Based on an interview at Administrator inserviced the DON/ the time of records review, the Maintenance Maintenance Supervisor/All Director stated documentation for testing of staff department heads / designee on knowledge on the EPP could not be found. the requirement to ensure all staff demonstrate knowledge of the This finding was reviewed with the Director of EPP trainings to meet set Nursing and Maintenance Director during the exit standards. conference. DON/Maintenance Supervisor/ All department heads / designee will work with the

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Administrator to ensure all staff demonstrate knowledge of the EPP trainings to meet set standards. If any issues are

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLET			ETED	
		155150	B. W	ING		11/20/	/2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILITY			MBIA CITY, IN 46725		
***	. C. CCLOIVIDIA O	CALLED HOROHO I AGILITI		JOLON	10		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					discovered, they will be addre	ssed	
					and resolved immediately.		
					c The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:	ıro	
					a At least annually to ensu		
					compliance, the Administrator DON/Maintenance	and	
					Supervisor/designee will revie	w tho	
					Emergency Preparedness Pol		
					Manual and conduct required	Ю	
					exercises and make changes	26	
					necessary to meet set standar		
					Those reviews will be docume		
					as appropriate. The Administra		
					will present the training results		
					the Quality Assurance/	Jul	
					Performance Improvement (Q	A/PI)	
					meeting. Results and system	,	
					components will be reviewed l		
					the QA/PI Committee with	,	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is		
					12/18/24.		
14 0000							
K 0000							
Dida 04							
Bldg. 01	A T : fo C - f - f - C 1	(I CC) December out: 1 Ct-t-	17.0	000			
	A Life Safety Code	(LSC) Recertification and State	K 0	000			I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2024	
	ROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	ras conducted by the Indiana th in accordance with 42 CFR			
	Survey Date: 11/20)/24			
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	55150			
	Skilled Nursing Fac compliance with Re Medicare/Medicaid Life Safety from Fir	-			
	Type II (222) constructions sprinklered. The far with smoke detection to the corridor and laterators in the resistance.	ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open pattery operated smoke dent rooms. The facility has a mad a census of 26 at the time			
	access are sprinkler	residents have customary ed. The facility does have a lity services that was not			
	Quality Review con	npleted on 11/26/24			
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure			
Bldg. 01		on and interview, the facility f 6 storerooms rooms greater	K 0321	It is the intent of the facility the ensure storeroom rooms greaters.	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/20/2024		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF COLUMBIA CI	TY SKILLED NURSING FACILITY			ELLSWORTH ST IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and being used for storage of mbustibles were protected as			than 50 square feet and being		
	_	his deficient practice could			used for storage of large amo		
	affect staff on the lo	_			of combustibles are protected hazardous area to meet set	as a	
	affect staff off the fo	ower level.			standards.		
	Findings include:				1 CORRECTIVE ACTION	s	
	i mumgs menuer				TAKEN:	•	
	Based on observation	ons with the Maintenance			a On or before 12/18/24, t	he	
	Director on 11/20/2	4 at 12:45 p.m., rooms 23 and 25			Maintenance Supervisor/desig		
	on the lower level c	ontained over 25 boxes of			added door closures to rooms		
	supplies, 20 plastic	PPE carts, were greater than 50			and 25 to ensure door self clo	ses	
		re making the rooms hazardous			and latches to meet set		
areas. The two rooms were not protected as				standards. The Administrator			
		eause the corridor doors to the			verified the work on 12/18/24		
		-closing or automatic closing.			2 ALL OTHERS WITH		
		ew at the time of observation,			POTENTIAL TO BE AFFECT	ED:	
		rector agreed the two rooms			a All residents and all staf		
		ounts of combustible storage,			and visitors have the potential	to	
		square feet, and the corridor			be affected but none were.		
	doors to the rooms v	were not self-closing.			3 MEASURES TO PREVE	NT	
	Th: - C., 1:				REOCCURRENCE:	l	
		viewed with the Director of enance Director during the exit			a On or before 12/18/24, t	ne	
	conference.	mance Director during the exit			Administrator inserviced the Maintenance Supervisor/design	nnoo	
	conference.				and all staff on the requirement		
	3.1-19(b)				ensure hazardous areas are	10	
	(-)				equipped with a self-closing d	oor	
					to meet set standards.		
					b Maintenance		
					Supervisor/designee will ensu	re	
					hazardous areas are equippe		
					with a self-closing door as a p	art	
					of the facility's monthly Preve	ntive	
					Maintenance Program and		
					document those inspection re		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. The		
					Maintenance Supervisor/designal will review with the Administra	-	
					I WILL FOULDW WITH THE AMBINISTS	uc)r	1

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIE	R ITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353	NFPA 101			the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed at the QA/PI Committee with subsequent plans of correction developed and implemented at 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.	nily ce
SS=E Bldg. 01	Sprinkler System Based on observation	- Maintenance and Testing on and interview, the facility	K 0353	- It is the intent of the facility t	0 12/18/2024
	room in the kitcher 25, 2011 edition, a show signs of leak	f 4 sprinklers in the cooking a were free of corrosion. NFPA t 5.2.1.1.1 sprinklers shall not age; shall be free of corrosion, paint, and physical damage; and		ensure sprinklers in the cookir room in the kitchen are free of corrosion to meet set standard 1.CORRECTIVE ACTIONS TAKEN:	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155150	B. W	ING		11/20	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILITY			MBIA CITY, IN 46725		
VV/ (L ()		THE CRIEDED NORTH TROIDER		OOLON	1017 (117 40720		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the correct orientation (e.g.,			1.On 12/10/24, facilities		
	up-right, pendent, or sidewall). Furthermore, at				licensed sprinkler contractor		
		kler that shows signs of any of			replaced the two sprinkler hea		
	_	be replaced: (1) Leakage (2)			in the kitchen by the stoves to)	
		ical Damage (4) Loss of fluid in responsive element (5)			meet set standards. The	le = =	
	_	responsive element (3)			Administrator verified the worl 12/10/24.	K OH	
	• • •	urer. This deficient practice			2.ALL OTHERS WITH		
	could affect staff or	-			POTENTIAL TO BE AFFECTI	ED:	
	could affect staff of	if the bottom story.			1.All residents and all sta		
	Findings include:				and visitors have the potential		
	i mamga meraac.				be affected but none were.	110	
	Based on observation with the Maintenance				3.MEASURES TO PREVEN	т	
		24 at 12:30 p.m., the			REOCCURRENCE:	•	
		s in the kitchen by the stoves			1.On or before 12/18/24,	the	
	_	owed signs of corrosion. Based			Administrator in serviced the		
	_	the time of observation, the			Maintenance Supervisor/desig	gnee	
	Maintenance Direc	tor agreed two sprinkler heads			on the requirement to ensure	•	
	in the kitchen show	ved signs of corrosion.			sprinkler in the cooking room	in	
					the kitchen are free of corrosic		
	This finding was re	eviewed with the Director of			meet set standards.		
	Nursing and Maint	enance Director during the exit			2.Maintenance		
	conference.				Supervisor/designee will ensu	ıre	
					sprinkler in the cooking room	in	
	3.1-19(b)				the kitchen are free of corrosion	on as	
					a part of the facility's Preventi	ve	
					Maintenance Program and		
					document those inspection re		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig	_	
					will review with the Administra	itor	
					the inspection results.		
					3.The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
	İ		1		documentation is in place.		1

CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150		ILDING	nstruction <u>01</u>	(X3) DATE S COMPLI 11/20/	ETED
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
K 0355	NFPA 101				4.MONITORING CORRECTION: 1.The inspection results was presented by the Maintenar Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/18/24.	vill nce lly se	
SS=E Bldg. 01	failed to ensure 1 of extinguishers were a pressure gauge read operable range or possible range or poperable range or possible range or po	view and interview, the facility 1 K-class portable fire repaired or replaced when the ing or indicator was not in the osition. 2.2 states periodic inspection oring of fire extinguishers shall at least the following items: gnated place o access or visibility reading or indicator in the	K 03	355	 It is the intent of the facility to ensure K class portable fire extinguishers are repaired or replaced when the pressure gareading or indicator is not in the operable range or position to noset standards. CORRECTIVE ACTIONS TAKEN: a On 12/10/24, the Administrator/Maintenance Supervisor/designee replaced K class fire extinguisher locate 	auge e neet the	12/18/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/20/2024 155150 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 640 W ELLSWORTH ST WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY COLUMBIA CITY, IN 46725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE selfexpelling-type extinguishers, the kitchen to meet set cartridge-operated extinguishers, and pump tanks standards. The Administrator (5) Condition of tires, wheels, carriage, hose, and verified the relocation on 12/10/24 nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers **ALL OTHERS WITH** using pushto-test pressure indicators POTENTIAL TO BE AFFECTED: Section 7.2.3 Corrective Action states when an All residents and all staff inspection of any fire extinguisher reveals a and visitors have the potential to deficiency in any of the conditions listed in 7.2.2, be affected but none were. immediate corrective action shall be taken. **MEASURES TO PREVENT** This deficient practice affects staff in the kitchen. REOCCURRENCE: On or before 12/18/24, the Findings include: Administrator inserviced the Maintenance Supervisor/and all Based on observation with the Maintenance dietary staff on the requirement Director on 11/20/24 at 12:32 p.m., the gauge on that portable fire extinguishers the K-class fire extinguisher in the kitchen showed must be repaired or replaced when the pressure gauge out of range due to high pressure gauge reading or pressure. Based on an interview during records indicator is not in operable range review, the Maintenance Director stated the or position to meet set standards. extinguisher was overcharged and needed Maintenance replaced. Supervisor/designee will ensure portable fire extinguishers are This finding was reviewed with the Director of repaired or replaced when Nursing and Maintenance Director during the exit pressure gauge reading or conference. indicator is not in operable range or position as a part of the facility's monthly Preventive

3.1-19(b)

The Administrator will monitor adherence to the Preventative Maintenance

schedule and validate the

the inspection results.

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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EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTI A. BUILDI B. WING	IPLE CONSTRUCTION ING 01	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED 11/20/2024	
	PROVIDER OR SUPPLIED	R SITY SKILLED NURSING FACILIT	64	TREET ADDRESS, CITY, STATE, ZIP COD 40 W ELLSWORTH ST OLUMBIA CITY, IN 46725			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		IE PRE	PROVIDER'S PLAN OF CORRECT	ED BE COPRIATE	(X5) COMPLETION DATE		
				4 MONITORING CORRECTIVE ACTION: a The inspection result be presented by the Main Supervisor/designee to the Administrator monthly and Administrator will present inspection results at the magnetic provides and systems of the Qa/PI) meet the Qa/PI Committee with subsequent plans of correct developed and implement deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance 12/18/24.	Its will tenance e d the the nonthly mance eting. stem wed by n ection ted as sure		
K 0511 SS=E Bldg. 01	failed to ensure 1 o satellite kitchen con protected from dam Article 406.6, Rece	Electric on and interview, the facility of 2 electrical outlets in the ntained a cover plate and was lage. NFPA 70, 2011 Edition. ptacle Faceplates (Cover expertacle faceplates shall be	K 0511	- It is the intent of the faci ensure electrical outlets in satellite kitchen contained plate and was protected find damage to meet set stand	n the I a cover rom dards.	12/18/2024	

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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

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TAKEN:

On 12/10/24, the

installed a cover plate on the

electrical outlet in the satellite

Maintenance Supervisor/designee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2024	
	F PROVIDER OR SUPPLIEI	R ITY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
WATE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF deficient practice of smoke compartmen Findings include: Based on observati Director on 11/20/2 kitchen there was a cover plate exposin interview at the tim Maintenance Direct missing a cover plat contacts visible. This finding was re-	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION build affect 15 residents in one			ED: f I to ENT the gnee Detion tire Detion hly ram on f ill be
				4 MONITORING CORRECTIVE ACTION:	dil

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
MUDILAN	or connection	155150					2024
		100100	D. 1111			11/20/	
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP COD		
\\\\\		TV CIVILLED AU IDOING FACULTS			ELLSWORTH ST		
WATERS	OF COLUMBIA CI	TY SKILLED NURSING FACILITY		COLUM	IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the	_	
					inspection results at the month	-	
					Quality Assurance/Performand		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed the QA/PI Committee with	ру	
					-,	2	
				subsequent plans of correction developed and implemented a			
				deemed necessary to ensure	13		
				compliance is maintained.			
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	า	
					all regulatory requirements.		
					Our date of compliance is		
					12/18/24.		
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens	1					12/18/2024
		on and interview, the facility	K 0920		· ·	It is the intent of the facility to	
		f 1 extension cords and 2 of 2			ensure extension cords includ	•	
		ot used as a substitute for			power strips are not used as a	l	
		r met the III rating of 1363 A or			substitute for fixed wiring to	0	
	_	r met the UL rating of 1363A or care locations according to			provide power equipment with		
	_	9 and NFPA-70/2011, 400.8.			high current draw or met the U)L	
	_	ice could affect 4 residents.			rating of 1363A or 60601-1 in patient care area locations		
	This deficient practi	rec could affect 7 residents.			according to LSC/2012 chapte	ar 10	
	Findings include:				and NFPA 70/2011, 400.8 to r		
	1 manigo morado.				set standards.		
	Based on observation	ons with the Maintenance			1.CORRECTIVE ACTIONS		
		4 at 11:52 a.m., the following			TAKEN:		
		use of power strips and			1.On 11/20/24, the		
	extension cords:				Maintenance Supervisor/desig	nee	
	A.) In room 15 an e	xtension cord was used to			removed the extension cord fr		

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	FEMENT OF DEFICIENCIES PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155150	(X2) MULTIPLE C A. BUILDING B. WING	Onstruction 01	(x3) date survey completed 11/20/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725			
(X4) PREI TA	TIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	meet 1363A or or resident's electron Based on intervior Maintenance Di and power-strips were being used. This finding was	d 15 a power-strip that did not 50601-1 was used to power the		room 15 to meet set standards. The Administrator verified the removal on 11/21/24. 2.On 11/20/24, the Maintenance Supervisor/designer removed the power strips from room 7 & 15 to meet set standards. The Administrator verified the removal on 11/21/2 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all stand visitors have the potential be affected but none were. Or 11/20/24, the Maintenance Supervisor/designee inspected rooms throughout the facility for power strips and extension con and found no other negative findings. 3.MEASURES TO PREVENT REOCCURRENCE: 1.On or before 12/18/24, Administrator inserviced the Maintenance Supervisor/designee/all other sthat power strips and extension cords are not to be used as a substitute for fixed wiring to me set standards. 2.Maintenance Supervisor/designee will inspecial 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 approprial fany issues are discovered, the monthly issues are discovered, the program and discovered, the program and discovered, the program is the program and document those inspection results as approprial fany issues are discovered, the program and discovered and the program and d	nee 24. ED: Iff to n d all or rds I the staff n eet ct y n ce stee.	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155150	A. BUILDING <u>01</u> B. WING		COMPLETED 11/20/2024				
155 150			<u> </u>		11/20/2024				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST									
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY COLUMBIA CITY, IN 46725									
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE					
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY) DA'					
				will be addressed and resolve					
				immediately. The Maintenand	I				
				Supervisor/designee will revie	W				
				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 CORRECT	IVE				
				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 montl	hly				
				Quality Assurance/Performan	ce				
				Improvement (QA/PI) meeting	I				
				Inspection results and system	I				
				components will be reviewed	by				
				the QA/PI Committee with					
				subsequent plans of correction	I				
				developed and implemented a	as				
				deemed necessary to ensure					
				compliance is maintained.					
				This plan of correction constitutes our credible					
				allegation of compliance with	h				
				all regulatory requirements.	"				
				Our date of compliance is					
				12/18/24.					
				Requesting paper					
				compliance.					

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