| DEPARTMENT OF HEALTH AND HUMAN SERVICES | |
|--|--|
| CENTERS FOR MEDICARE & MEDICAID SERVICES | |

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--------------------------|---|--|--|---------------------|--|---|----------------------------|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | | 524 AN | ADDRESS, CITY, STATE, ZIP COD IDERSON RD ERFIELD, IN 46017 | | |
| (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 |
| E 0000 Bldg | conducted by the In accordance with 42 Survey Date: 01/24 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I of Chesterfield Skill not in compliance w Requirements for M Participating Provid 483.73. The facility census of 40 at the t Quality Review con Quality Review con 403.748(d)(1), 446 441.184(d)(1), 485 486.360(d)(1), 485 486.360(d)(1), 485 486.360(d)(1), \$26 EP Training Progression 142 EP Training Progression 142 Survey Date: 01/24 EP Training Progression 142 EP Training Progression 142 Survey Date: 01/24 EP Training Progression 142 EP Training Progression 143 EP Train | 20524 55617 267090 Preparedness survey, Waters led Nursing Facility was found with Emergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR has a capacity of 60 and had a lime of this survey. Impleted on 01/30/23 2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1), 1.12(d)(1) | E 00 | 000 | Name of Provider or Supplier The Waters of Chesterfield ID #155617 Address - 524 Anderson Road Chesterfield, IN 46017 Date Survey Completed - 1/24/23 DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegation substantial compliance with Federal Medicare and Medicaid requirements. | d, the set red ce | |
| LABORATOR | Y DIRECTOR'S OR PROV | /IDER/SUPPLIER REPRESENTATIVE'S SIGN | NATURI | 3 | TITLE | | (X6) DATE |

Kimberly Locke **HFA** 02/16/2023

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

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | OM | IB NO. 0938-039 | | |
|--|--|---|---|---|--|----|----------------------------|--|--|
| | X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | | | | | ESURVEY LETED H/2023 | | |
| | PROVIDER OR SUPPLIE | ELD SKILLED NURSING FACILI | TV | STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017 | | | | | |
| | 1 | | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' | | | | | | |
| (X4) ID | | Y STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTIO | | (X5) | | |
| PREFIX | , and the second | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | COMPLETION | | |
| TAG | | OR LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCII | | DATE | | |
| | §485.68(d)(1), § (1), §485.920(d)(§491.12(d)(1). | 183.475(d)(1), §484.102(d)(1), 485.625(d)(1), §485.727(d) 1), §486.360(d)(1), §403.748, ASCs at §416.54, | | | | | | | |
| | | 2.15, ICF/IIDs at §483.475, | | | | | | | |
| | | 02, "Organizations" under | | | | | | | |
| | §485.727, OPOs | at §486.360, RHC/FQHCs | | | | | | | |
| | at §491.12:] | | | | | | | | |
| | 1 ' ' | gram. The [facility] must do | | | | | | | |
| | all of the following | • | | | | | | | |
| | (i) Initial training in emergency preparedness | | | | | | | | |
| | 1 ' | edures to all new and | | | | | | | |
| | _ | ividuals providing services | | | | | | | |
| | | ent, and volunteers, neir expected roles. | | | | | | | |
| | | gency preparedness training | | | | | | | |
| | at least every 2 y | | | | | | | | |
| | | umentation of all emergency | | | | | | | |
| | preparedness tra | | | | | | | | |
| | | staff knowledge of | | | | | | | |
| | emergency proce | _ | | | | | | | |
| | | ncy preparedness policies | | | | | | | |
| | 1 \ / | are significantly updated, the | | | | | | | |
| | | nduct training on the | | | | | | | |
| | updated policies | - | | | | | | | |
| | *[For Hospices at | t §418.113(d):] (1) Training. | | | | | | | |
| | 1 - | st do all of the following: | | | | | | | |
| | - | in emergency preparedness | | | | | | | |
| | | edures to all new and | | | | | | | |
| | 1 ' | employees, and individuals | | | | | | | |
| | | s under arrangement, | | | | | | | |
| | | neir expected roles. | | | | | | | |
| | (ii) Demonstrate | staff knowledge of | | | | | | | |
| | emergency proce | | | | | | | | |
| | | gency preparedness training | | | | | | | |
| | at least every 2 y | ears. | | | | | | | |

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(iv) Periodically review and rehearse its

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---------------------------|--|---|---------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | | COMPL | ETED |
| | | 155617 | B. WI | NG | _ | 01/24/ | 2023 |
| NAME OF P | PROVIDER OR SUPPLIER | <u>.</u> | | | ADDRESS, CITY, STATE, ZIP COD DERSON RD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | CHEST | ERFIELD, IN 46017 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | redness plan with hospice | | | | | |
| | | ding nonemployee staff), lasis placed on carrying out | | | | | |
| | · · | ecessary to protect patients | | | | | |
| | and others. | | | | | | |
| | | mentation of all emergency | | | | | |
| | preparedness training. | | | | | | |
| | | ncy preparedness policies | | | | | |
| | | re significantly updated, the | | | | | |
| | hospice must cond | duct training on the | | | | | |
| | updated policies and | | | | | | |
| | procedures. | | | | | | |
| | program. The PRT following: (i) Initial training in policies and proce existing staff, indivunder arrangemer consistent with the (ii) After initial train preparedness train (iii) Demonstrate semergency proced (iv) Maintain docupreparedness train (v) If the emergent and procedures and PRTF must condu | eir expected roles. ning, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, the uct training on the updated | | | | | |
| | organization must (i) Initial training in policies and proce existing staff, indiv services under arr | 60.84(d):] (1) The PACE to do all of the following: n emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with | | | | | |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | X2) MULTIPLE CONSTRUCTION | | | SURVEY |
|---------------------------|---|-------------------------------|--------|---------------------------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPL | ETED |
| | | 155617 | B. W | ING | | 01/24 | /2023 |
| | | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIER | ₹ | | 1 | DERSON RD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | , | | ERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | , , | ency preparedness training | | | | | |
| | at least every 2 ye | ears. staff knowledge of | | | | | |
| | ' ' | dures, including informing | | | | | |
| | | | | | | | |
| | participants of what to do, where to go, and whom to contact in case of an emergency. | | | | | | |
| | (iv) Maintain documentation of all training. | | | | | | |
| | ' ' | ncy preparedness policies | | | | | |
| | | re significantly updated, the | | | | | |
| | - | uct training on the updated | | | | | |
| | policies and procedures. | | | | | | |
| | | | | | | | |
| | *[For LTC Facilities at §483.73(d):] (1) | | | | | | |
| | Training Program. The LTC facility must do all | | | | | | |
| | of the following: | | | | | | |
| | | n emergency preparedness | | | | | |
| | | edures to all new and | | | | | |
| | _ | viduals providing services | | | | | |
| | _ | nt, and volunteers, | | | | | |
| | consistent with the | - | | | | | |
| | , , | ency preparedness training | | | | | |
| | at least annually. | mentation of all emergency | | | | | |
| | preparedness trai | 0 2 | | | | | |
| | | staff knowledge of | | | | | |
| | emergency proce | _ | | | | | |
| | omergency proce | uu. 00. | | | | | |
| | *IFor CORFs at & | 485.68(d):](1) Training. The | | | | | |
| | CORF must do al | | | | | | |
| | | raining in emergency | | | | | |
| | | icies and procedures to all | | | | | |
| | | staff, individuals providing | | | | | |
| | | rangement, and volunteers, | | | | | |
| | consistent with the | eir expected roles. | | | | | |
| | (ii) Provide emergency preparedness training | | | | | | |
| | at least every 2 years. | | | | | | |
| | (iii) Maintain documentation of the training. | | | | | | |
| | ' ' | staff knowledge of | | | | | |
| | | dures. All new personnel | | | | | |
| | must be oriented | and assigned specific | | | | | |

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| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | l í | UILDING | NSTRUCTION | COM | e survey pleted 4/2023 |
|--------------------------|--|--|----------|---------------------|--|---------------------------|------------------------------|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | <i>,</i> | 524 ANI | NDDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY) | TION LD BE ROPRIATE | (X5) COMPLETION DATE |
| | responsibilities regemergency plan workday. The traininstruction in the less systems and signal equipment. (v) If the emerge and procedures and disaster authorized and disaster authorized and disaster authorized and procedures to all remergency proposedures to all remergency provide individuals provided and provided and procedures to all remergency procedures to all remergency provided and provided and provided and provided and procedures to all remergency provided and provided and provided and procedures to all remergency provided and provided | garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting and preparedness policies are significantly updated, the uct training on the updated edures. 85.625(d):] (1) Training and must do all of the are emergency preparedness edures, including prompt anguishing of fires, and energency evacuation and, and guests, fire properation with firefighting porities, to all new and widuals providing services and, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. It is afficiently updated, the extraining on the updated edures. 485.920(d):] (1) Training. provide initial training in redness policies and new and existing staff, | | | | | |

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| CENTERS FO | R MEDICARE & MEDIC | CAID SERVICES | | | OMB NO. 0938-039 | |
|------------|----------------------|----------------------------------|-----------------|--|-------------------|--|
| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | <u></u> | COMPLETED | |
| | | 155617 | B. WING | | 01/24/2023 | |
| | | | CTD FFT | ADDRESS CITY CTATE TIP COD | | |
| NAME OF | PROVIDER OR SUPPLIEI | R | | ADDRESS, CITY, STATE, ZIP COD | | |
| \A/A.TED | 0.05.01150750515 | U D OKU I ED NU IDOINO EAOU IT | | NDERSON RD | | |
| WATER | S OF CHESTERFIE | LD SKILLED NURSING FACILIT | Y CHES | TERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | their expected role | es, and maintain | | | | |
| | • | the training. The CMHC | | | | |
| | | e staff knowledge of | | | | |
| | | dures. Thereafter, the | | | | |
| | CMHC must provi | | | | | |
| | | ning at least every 2 years. | | | | |
| | | view and interview, the facility | E 0037 | E027 It is the intent of the for | oility 02/16/2022 | |
| | | nnual training for the | E 003/ | E037 – It is the intent of the factor to ensure to conduct annual | cility 02/16/2023 | |
| | | 6 | | | | |
| | | edness Program (EPP). The LTC | | training for the Emergency | | |
| | - | of the following: (i) Initial | | Preparedness Program (EPP) | TO | |
| | | ncy preparedness policies and | | meet set standards. | _ | |
| | 1 - | ew and existing staff, | | 1. CORRECTIVE ACTIONS | 5 | |
| | _ | ng services under arrangement, | | TAKEN: | | |
| | | sistent with their expected | | a. On 2/6/23 the Administr | ator | |
| | | emergency preparedness | | and the Maintenance | | |
| | _ | nually; (iii) Maintain | | Supervisor/designee updated | | |
| | | ll emergency preparedness | | Emergency Preparedness Pol | - | |
| | | onstrate staff knowledge of | | Manual to include annual train | ing | |
| | | res in accordance with 42 CFR | | and to show staff could | | |
| | | deficient practice could affect | | demonstrate knowledge of the | | |
| | all residents in the | facility. | | EPP to meet set standards. | | |
| | | | | 2. ALL OTHERS WITH | | |
| | Findings include: | | | POTENTIAL TO BE AFFECTE | ED: | |
| | | | | a. All residents and all staf | f | |
| | Based on records re | eview with the Administrator | | and visitors have the potential | to | |
| | and the Maintenand | ce Director on 01/24/2023 at | | be affected but none were. The | ne | |
| | 3:30 p.m., no docur | mentation of annual EEP | | facility has only one Emergend | су | |
| | training and no doc | rumentation to show staff | | Preparedness Policy Manual. | | |
| | could demonstrate | knowledge of the EPP was | | 3. MEASURES TO PREVE | NT | |
| | | v. Based on an interview at the | | REOCCURRENCE: | | |
| | time of records rev | iew, the Administrator stated | | a. On 2/6/233 the | | |
| | | of the EEP training was | | Administrator inserviced the | | |
| | available for review | _ | | Maintenance Supervisor/desig | inee | |
| | | | | on the requirement that the | | |
| | This finding was re | eviewed with the Administrator | | Emergency Preparedness Pol | icv | |
| | 1 | Director during the exit | | Manual must include annual | , , | |
| | conference. | mount during the Oak | | training and to show staff could | d | |
| | Jointorenee. | | | demonstrate knowledge of the | | |
| | 3 1-10(b) | | | _ | | |
| | 3.1-19(b) | | 1 | EPP to meet set standards. | ĺ | |

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b.

On 2/10/23 the

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| | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION | COMP | E SURVEY PLETED 1/2023 |
|--------------------------|---------------------------------|---|--|---|--|------------------------------|
| | ROVIDER OR SUPPLIE | R ELD SKILLED NURSING FACILIT | 524 AN | ADDRESS, CITY, STATE, ZIP CO NDERSON RD FERFIELD, IN 46017 | OD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | RECTION OULD BE PPROPRIATE | (X5) COMPLETION DATE |
| | | | | Administrator conducte emergency preparedne with all staff and obtains copies of the Emergency Preparedness Policy M Certification to be filed employee's personnel find developed a tracking resemency preparedness which includes all curresemployee names, start dates of initial training a of annual training to mestandards. c. The Administrato Maintenance Supervisor will review and update of Emergency Preparedness Manual at least annually changes occur to meet standards. if any issued discovered, they will be and resolved immediated. The Administrator monitor adherence to the Emergency Preparedness Manual and validate the documentation is in plass. At least annually compliance, the Administrator will review the Emerger Preparedness Policy Maintenance Supervisor will review the Emerger Preparedness Policy Make changes as necemet set standards. The reviews will be documentation. | ed signed cy anual in each file and ecord of ess training ent dates, and dates eet set or and or/designee the ess Policy ly or as set s are addressed ely. or will ne ess Policy e ce. It to ensure istrator and or/designee ncy lanual and essary to nose | |

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING | | | | X3) DATE SURVEY COMPLETED 01/24/2023 | |
|------------------------|--|---|---|--------|--|--------|--|--|
| | | 100017 | B. WI | | | 01/24/ | 2023 | |
| | PROVIDER OR SUPPLIEI S OF CHESTERFIE | R ELD SKILLED NURSING FACILITY | | 524 AN | ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | | | | This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 16, 2023. | า | | |
| E 0039 SS=F Bldg | 441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § (2), §491.12(d)(2) *[For ASCs at §4* OPO, "Organizati CMHCs at §485.9 §491.12, and ESF (2) Testing. The [fexercises to test to annually. The [factor) following: (i) Participate in a community-based (A) When a community-based (B) If the [factor) not accessible, continuation of the exempt from exempt from exempt from exempt from exempt from exempt community-based (B) If the participate in a community-bas | 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) | | | | | | |

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| AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | | ľ í | UILDING | NSTRUCTION | COMI | E SURVEY PLETED 4/2023 | |
|---|--|---|---------|---------------------|---|------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | , | 524 ANI | DDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY) | O BE | (X5) COMPLETION DATE |
| | actual event. (ii) Conduct an ad every 2 years, oppor functional exercity of this section is include, but is not (A) A second full-scommunity-based functional exercises (B) A mock disaste (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an erection (iii) Analyze the [famaintain documerexercises, and emethe [facility's] emethe [facility's] emethe [facility's] emethe patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based (B) If the hospice of man-made emerging of the emergency exempt from engal scale community- | ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based exercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. acility's] response to and nation of all drills, tabletop hergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in exercise that provide care in exercise the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the | | | | | |

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| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | r í | UILDING | NSTRUCTION | | LETED L/2023 |
|--------------------------|--|--|-----|---------------------|---|---------------------|----------------------------|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | , | 524 ANI | DDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ON DBE PRIATE | (X5) COMPLETION DATE |
| | years, opposite the functional exercises of this section is or include, but is not (A) A second full-community-based functional exercises (B) A mock disass (C) A tabletop excled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepto challenge an er (3) Testing for hos care directly. The exercises to test the per year. The hos (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engate full-scale community functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full- | ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required hity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or | | | | | |

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Event ID:

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Facility ID: 000524

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PRINTED: 02/28/2023
FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | ON | IB NO. 0938-039 |
|--|--|--|-------|---------|--|-----------|-----------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | l í | | NSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | 1 | JILDING | | COMPI | |
| | | 155617 | B. Wl | | | 01/24 | 12023 |
| NAME OF I | PROVIDER OR SUPPLIER | Ł | | | ADDRESS, CITY, STATE, ZIP COD | | |
| \\/\TED | S OE CHESTEDEIE | LD SKILLED NURSING FACILITY | | | DERSON RD ERFIELD, IN 46017 | | |
| WATERS | OF CHESTERFIE | LD SKILLED NORSING FACILITY | | CHEST | ERFIELD, IN 40017 | | • |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCIT | | DATE |
| | . , | ercise or workshop led by a udes a group discussion | | | | | |
| | using a narrated, | • . | | | | | |
| | _ | rio, and a set of problem | | | | | |
| | | ed messages, or prepared | | | | | |
| | questions designe | - · · · · · · · · · · · · · · · · · · · | | | | | |
| | emergency plan. | a to shallonge an | | | | | |
| | | ospice's response to and | | | | | |
| | . , , | ntation of all drills, tabletop | | | | | |
| | exercises, and emergency events and revise | | | | | | |
| | the hospice's emergency plan, as needed. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | 41.184(d), Hospitals at | | | | | |
| | §482.15(d), CAHs | . , - | | | | | |
| | , , | PRTF, Hospital, CAH] must | | | | | |
| | | to test the emergency | | | | | |
| | 1 | r. The [PRTF, Hospital, | | | | | |
| | CAH] must do the | _ | | | | | |
| | | n annual full-scale exercise | | | | | |
| | that is community | | | | | | |
| | | nunity-based exercise is not ct an annual individual, | | | | | |
| | facility-based fund | • | | | | | |
| | | Hospital, CAH] experiences | | | | | |
| | . , | or man-made emergency | | | | | |
| | | ation of the emergency | | | | | |
| | • | s exempt from engaging in | | | | | |
| | | ıll-scale community based | | | | | |
| | 1 | ty-based functional exercise | | | | | |
| | | t of the emergency event. | | | | | |
| | _ | an [additional] annual | | | | | |
| | | at may include, but is not | | | | | |
| | limited to the follow | - | | | | | |
| | (A) A second full- | scale exercise that is | | | | | |
| | community-based | or individual, a | | | | | |
| | facility-based fund | tional exercise; or | | | | | |
| | ` ' | ck disaster drill; or | | | | | |
| | (C) A tabletop | exercise or workshop that | | | | | |

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is led by a facilitator and includes a group

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|-----------|---------------------------------------|--------------------------------|--------|---------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | <u></u> | COMPLETED | |
| | | 155617 | B. W | ING | | 01/24 | /2023 |
| | | | | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | <u> —</u> | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | DERSON RD | | |
| WATERS | S OF CHESTERFIE | ELD SKILLED NURSING FACILITY | | | ERFIELD, IN 46017 | | |
| WATER | · · · · · · · · · · · · · · · · · · · | LED GRIELED NORGING I ACIEIT I | | OHLOI | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | discussion, using | | | | | | |
| | 1 | emergency scenario, and a | | | | | |
| | | atements, directed | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an e | | | | | | |
| | , , , | he [facility's] response to | | | | | |
| | | umentation of all drills, | | | | | |
| | | s, and emergency events | | | | | |
| | I - | cility's] emergency plan, as | | | | | |
| | needed. | | | | | | |
| | *[For PACE at §4 | 60 84(d)·1 | | | | | |
| | - | PACE organization must | | | | | |
| | . , | s to test the emergency | | | | | |
| | plan at least annu | | | | | | |
| | organization must | - | | | | | |
| | _ | an annual full-scale exercise | | | | | |
| | that is community | | | | | | |
| | | nunity-based exercise is not | | | | | |
| | | uct an annual individual, | | | | | |
| | | ctional exercise; or | | | | | |
| | | xperiences an actual natural | | | | | |
| | * * | ergency that requires | | | | | |
| | activation of the e | emergency plan, the PACE | | | | | |
| | | ngaging in its next required | | | | | |
| | full-scale commun | nity based or individual, | | | | | |
| | facility-based fund | ctional exercise following the | | | | | |
| | onset of the emer | gency event. | | | | | |
| | (ii) Conduct a | an additional exercise every | | | | | |
| | 2 years opposite | the year the full-scale or | | | | | |
| | functional exercis | e under paragraph (d)(2)(i) | | | | | |
| | of this section is o | conducted that may include, | | | | | |
| | but is not limited t | _ | | | | | |
| | | -scale exercise that is | | | | | |
| | 1 | l or individual, a facility | | | | | |
| | based functional | | | | | | |
| | (B) A mock disas | | | | | | |
| | | ercise or workshop that is | | | | | |
| | I - | and includes a group | | | | | |
| | discussion, using | a narrated, | 1 | | | | |

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| STATEME | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE SURVEY | | |
|----------|--|---|--|------------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | | COMPLETED | |
| | | 155617 | B. W | ING | | 01/24 | /2023 | |
| NAME OF | DDOMDED OF STIPPT IS | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF | PROVIDER OR SUPPLIEI | X | | 524 AN | DERSON RD | | | |
| WATER | S OF CHESTERFIE | ELD SKILLED NURSING FACILITY | <u>, </u> | CHEST | ERFIELD, IN 46017 | | | |
| (X4) ID | | SUMMARY STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | CROSS-REFERENCED TO THE A | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | IATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCIT | | DATE | |
| | | emergency scenario, and a attements, directed | | | | | | |
| | | pared questions designed | | | | | | |
| | to challenge an e | | | | | | | |
| | | PACE's response to and | | | | | | |
| | | ntation of all drills, tabletop | | | | | | |
| | | nergency events and revise | | | | | | |
| | | gency plan, as needed. | | | | | | |
| | | | | | | | | |
| | *[For LTC Facilitie | - , , - | | | | | | |
| | . , - | ity] must conduct exercises | | | | | | |
| | 1 | ency plan at least twice per | | | | | | |
| | | announced staff drills using | | | | | | |
| | 1 | ocedures. The [LTC facility, | | | | | | |
| | ICF/IID] must do t | _ | | | | | | |
| | | an annual full-scale exercise | | | | | | |
| | that is community | | | | | | | |
| | | nunity-based exercise is not | | | | | | |
| | | uct an annual individual, | | | | | | |
| | facility-based fund | | | | | | | |
| | | cility] facility experiences an | | | | | | |
| | | man-made emergency that | | | | | | |
| | 1 - | n of the emergency plan, the | | | | | | |
| | 1 | mpt from engaging its next | | | | | | |
| | | ale community-based or based functional exercise | | | | | | |
| | 1 | et of the emergency event. | | | | | | |
| | I - | dditional annual exercise | | | | | | |
| | 1 ' ' | but is not limited to the | | | | | | |
| | following: | bat is not infinited to trie | | | | | | |
| | _ | -scale exercise that is | | | | | | |
| | | or an individual, facility | | | | | | |
| | based functional | | | | | | | |
| | (B) A mock disas | | | | | | | |
| | ` ' | ercise or workshop that is | | | | | | |
| | led by a facilitator | | | | | | | |
| | discussion, using | ~ · | | | | | | |
| | | emergency scenario, and a | | | | | | |
| | set of problem sta | atements, directed | | | | | | |
| | | pared questions designed | | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--|--|---|------|--|--|----|---------------------------------------|--|
| | OF PROVIDER OR SUPPLIE ERS OF CHESTERFIE | R ELD SKILLED NURSING FACILITY | Y | 524 ANI | DDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | - | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO | BE | (X5) COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | response to and r all drills, tabletop events, and revise | LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's | | | | | | |
| | exercises to test to twice per year. The following: (i) Participate in an athat is community. (A) When a community accessible, conductive facility-based functions of the ending exempt from ending exemp | S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the en annual full-scale exercise r-based; or munity-based exercise is not act an annual individual, ctional exercise; or. experiences an actual ade emergency plan, the ICF/IID engaging in its next requires emergency plan, the ICF/IID engaging in its next required exercise following the regency event. Iditional exercise following the engency event. Iditional annual exercise but is not limited to the escale exercise that is dor an individual, ctional exercise; or | | | | | | |
| | led by a facilitator discussion, using clinically-relevant set of problem sta messages, or pre to challenge an ei (iii) Analyze the IC | and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed | | | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | | UILDING | NSTRUCTION | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|-------------------|--|---|---------------|--------------|---|---------------------------------------|--------------------|
| | PROVIDER OR SUPPLIER | RILD SKILLED NURSING FACILITY | . ′ | 524 ANI | DDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TF | (X5) COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | nergency events, and revise rgency plan, as needed. | | | | | |
| | *[For HHAs at §48 (d)(2) Testing. The exercises to test ti least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility-every 2 years; or. (B) If the HH. natural or man-ma activation of the e exempt from engafull-scale community-based functional to the emergical community consection is consected include, but is not (A) A second community-based | e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is d; or community-based exercise conduct an annual based functional exercise A experiences an actual ade emergency that requires comergency plan, the HHA is deging in its next required conity-based or individual, citional exercise following the gency event. Iditional exercise every 2 de year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is | | | | | |
| | (B) A mock di | isaster drill; or p exercise or workshop that | | | | | |
| | · · | tor and includes a group | | | | | |
| | discussion, using | | | | | | |
| | | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an er | | | | | | |
| | | HA's response to and | | | | | |
| | | ntation of all drills, tabletop | | | | | |
| | exercises, and em | nergency events, and revise | | | | | |

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | JLTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|-----------|----------------------|---|--------|------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | | COMPL | ETED |
| | | 155617 | B. W | NG | | 01/24/ | /2023 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | DERSON RD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | | ERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | CRO | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | the HHA's emerge | ency plan, as needed. | | | | | |
| | *r= 000 104 | 20.001 | | | | | |
| | *[For OPOs at §48 | | | | | | |
| | | e OPO must conduct | | | | | |
| | | he emergency plan. The | | | | | |
| | OPO must do the | _ | | | | | |
| | | er-based, tabletop exercise | | | | | |
| | | ast annually. A tabletop | | | | | |
| | · · | a facilitator and includes a | | | | | |
| | 1 - ' | using a narrated, clinically | | | | | |
| | 1 | cy scenario, and a set of | | | | | |
| | 1 ' | nts, directed messages, or ns designed to challenge an | | | | | |
| | | f the OPO experiences an | | | | | |
| | | nan-made emergency that | | | | | |
| | | of the emergency plan, the | | | | | |
| | - | om engaging in its next | | | | | |
| | 1 | xercise following the onset | | | | | |
| | of the emergency | _ | | | | | |
| | | PO's response to and | | | | | |
| | 1 ' ' | ntation of all tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | | OPO's] emergency plan, as | | | | | |
| | needed. | or o of omorgoney plan, as | | | | | |
| | moodod. | | | | | | |
| | *[RNCHIs at §400 | 3.7481: | | | | | |
| | | e RNHCI must conduct | | | | | |
| | 1 ' ' ' ' | he emergency plan. The | | | | | |
| | RNHCI must do th | | | | | | |
| | | er-based, tabletop exercise | | | | | |
| | | A tabletop exercise is a | | | | | |
| | group discussion | led by a facilitator, using a | | | | | |
| | 1 - ' | r-relevant emergency | | | | | |
| | | et of problem statements, | | | | | |
| | directed message | s, or prepared questions | | | | | |
| | designed to challe | enge an emergency plan. | | | | | |
| | 1 | NHCI's response to and | | | | | |
| | maintain documer | ntation of all tabletop | | | | | |
| | exercises, and em | nergency events, and revise | | | | | |
| | the RNHCI's eme | rgency plan, as needed. | | | | | |

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | OM | IB NO. 0938-039 |
|--|-----------------------|----------------------------------|-----------------|------------------------------|---|------------------|-----------------|
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | | COMPL | LETED |
| | | 155617 | B. WI | NG | | 01/24 | /2023 |
| | | | _ | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | 524 ANDERSON RD | | | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | | ΓERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | I | ID | | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | * | LISC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| IAG | | view and interview, the facility | E 00 | | E020 It is the intent of the fe | oility | 02/16/2023 |
| | | ne of the required two exercises | EU | 139 | E039 – It is the intent of the far to ensure to conduct one of the | • | 02/10/2023 |
| | | by plan at least annually, | | | | | |
| | _ | iced staff drills using the | | | required two exercises to test | | |
| | _ | | | | emergency plan at least annua | - | |
| | | res. The LTC facility must do | | | including unannounced staff d | | |
| | the following: | 1.0.11 1 1 1 4 | | | using the emergency procedu | res | |
| | | annual full-scale exercise that | | | to meet set standards. | _ | |
| | is community-based | | | | 1. CORRECTIVE ACTION | S | |
| | | ity-based exercise is not | | | TAKEN: | | |
| | | an annual individual, | | | a. On 2/14/23 the | | |
| | facility-based functi | | | | Administrator and the | | |
| b. If the LTC facility experiences an actual natural | | | | Maintenance Supervisor/desig | jnee | | |
| | _ | gency that requires activation | | | conducted a facility based full | | |
| | | an, the LTC facility is exempt | | | scale annual exercise and | | |
| | | ext required full-scale in a | | | completed documentation for | | |
| | - | r individual, facility-based | | | exercise to meet set standards | S. | |
| | | l exercise for 1 year following | | | 2. ALL OTHERS WITH | | |
| | the onset of the actu | | | | POTENTIAL TO BE AFFECTE | | |
| | * * | itional exercise that may | | | a. All residents and all staf | | |
| | | mited to the following: | | | and visitors have the potential | to | |
| | a. A second full-sca | | | | be affected but none were. | | |
| | - | r an individual, facility-based | | | 3. MEASURES TO PREVE | ENT | |
| | functional exercise. | | | | REOCCURRENCE: | | |
| | b. A mock disaster | | | | a. On 2/6/23 the Administr | ator | |
| | _ | se or workshop that is led by a | | | inserviced the Maintenance | | |
| | | des a group discussion, using | | | Supervisor/designee on the | | |
| | | y-relevant emergency scenario, | | | requirement that a facility base | | |
| | - | n statements, directed | | | full scale annual exercise mus | | |
| | | red questions designed to | | | conducted at least annually ar | | |
| | challenge an emerge | | | | documentation retained to me | et | |
| | | C facility's response to and | | | set standards. | | |
| | | ation of all drills, tabletop | | | b. Maintenance | | |
| | | gency events, and revise the | | | Supervisor/designee will work | with | |
| | | gency plan, as needed in | | | the Administrator to ensure a | | |
| | | CFR 483.73(d)(2). This | | | facility based full scale annual | | |
| | deficient practice co | ould affect all occupants. | | | exercise is conducted and | | |
| | | | | | documented to meet set | | |
| | Findings include: | | | | standards. If any issues are | | |

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Based on record review with the Administrator

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discovered, they will be addressed

and resolved immediately.

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--|--|--|---------------------|---|--|
| | PROVIDER OR SUPPLIED | R ELD SKILLED NURSING FACILIT | 524 AI | ADDRESS, CITY, STATE, ZIP COD NDERSON RD TERFIELD, IN 46017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY O | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the Director on 01/24/2023 at | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) C. The Administrator will | (X5) COMPLETION DATE |
| | 03:30 p.m., no doct annual exercise wit for review. Based of records review, the Table Top exercise but a second exerci- months. | amentation of a facility based thin the last year was available on interview at the time of Administrator stated that a was completed on 05/10/2022 se was not done in the last 12 eviewed with the Administrator director at the exit conference. | | 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 Administrator Maintenance Supervisor/design will review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrator present the training results at Quality Assurance/ Performar Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI Committee with subsequent prof 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 February 16, 2023. | aure and gnee and to s or will the nce g. onts olans |
| K 0000 | | | | | |
| Bldg. 01 | | e Recertification and State was conducted by the Indiana | K 0000 | Name of Provider or Supplie The Waters of | r – |

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Event ID:

62V221

Facility ID: 000524

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|------------|--|---------------------------------|------------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPLE | | | ETED | |
| | | 155617 | B. W | NG | | 01/24/ | 2023 |
| | | | | CTREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 2 | | | DERSON RD | | |
| \A/A TED 6 | OF CHECTEREIE | LD CKILLED NILIDONIC EACH ITY | | | | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | CHEST | ERFIELD, IN 46017 | | |
| (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 BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | Department of Heal | lth in accordance with 42 CFR | | | Chesterfield | | |
| | 483.90(a). | | | | ID #155617 | | |
| | Survey Date: 01/24/2023 | | | | Address - 524 Anderson Road | d, | |
| | | | | | Chesterfield, IN 46017 | | |
| | | | | | Date Survey Completed | | |
| | Facility Number: 0 | 000524 | | | - 1 /24/23 | | |
| | Provider Number: 1 | 155617 | | | | | |
| | AIM Number: 100 | 267090 | | | DISCLAIMER STATEMENT: | | |
| | | | | | Preparation and/or execution | 1 | |
| | At this Life Safety | Code survey, Waters of | | | of this plan of correction in | | |
| | Chesterfield Skilled | Nursing Facility was found | | | general, or this corrective | | |
| | not in compliance v | vith Requirements for | | | action in particular, does not | | |
| | Participation in Me | dicare/Medicaid, 42 CFR | | | constitute an admission or | | |
| | Subpart 483.90(a), | Life Safety from Fire and the | | | agreement by this facility of | the | |
| | 2012 edition of the | National Fire Protection | | | facts alleged or conclusions | set | |
| | Association (NFPA | .) 101, Life Safety Code (LSC), | | | forth in this statement of | | |
| | Chapter 19, Existin | g Health Care Occupancies and | | | deficiencies. The plan of | | |
| | 410 IAC 16.2. | | | | correction and specific | | |
| | | | | | corrective actions are prepar | ed | |
| | This one story facil | ity was determined to be of | | | and/or executed in complian | ce | |
| | Type V (111) const | ruction and was fully | | | with state and federal laws. | | |
| | sprinklered. The fa | cility has a fire alarm system | | | This plan of correction | | |
| | with smoke detection | on in the corridors, areas open | | | constitutes a written allegation | on | |
| | to the corridors and | battery powered smoke | | | of substantial compliance wi | th | |
| | detectors in the resi | dent rooms. The facility has a | | | Federal Medicare and | | |
| | capacity of 60 and l | had a census of 40 at the time | | | Medicaid requirements. | | |
| | of this survey. | | | | | | |
| | | | | | | | |
| | | residents have customary | | | | | |
| | _ | ered. All areas providing | | | | | |
| | facility services we | re sprinklered. | | | | | |
| | | | | | | | |
| | Quality Review cor | mpleted on 01/30/23 | | | | | |
| IZ 0044 | NEDA 404 | | | | | | |
| K 0211 | NFPA 101 | | | | | | |
| SS=E | Means of Egress | | | | | | |
| Bldg. 01 | Means of Egress | | | | | | |
| | | ays, corridors, exit | | | | | |
| | - | ocations, and accesses are | | | | | |
| | in accordance wit | h Chapter 7, and the means | | | | | |

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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 COMPLETED 01 155617 B. WING 01/24/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (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 of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1. 19.2.1. 7.1.10.1 1. Based on observation and interview, the K 0211 K211 - It is the intent of the 02/16/2023 facility failed to ensure 2 of 5 corridor means of facility to ensure corridor means of egresses were continuously maintained free of egresses are continuously obstructions. This deficient practice affects 5 maintained free of obstructions to residents and 5 staff. meet set standards. 1. CORRECTIVE ACTIONS Findings include: TAKEN: On 1/25/23 the a. Based on observation during a tour of the facility Maintenance Supervisor/designee with the Maintenance Director on 01/24/2023 at removed the privacy curtain 2:05 p.m., at exit door 2 and exit door 5 there was a installed at each exit door 2 and privacy curtain installed at each exit that would exit door 5 that would obstruct obstruct egress when fully extended. Based on egress when fully extended to interview at the time of observations, the meet set standards. The Maintenance Director stated that if the the curtain Administrator verified the work on was extended it would obstruct exiting the 1/25/23. building. On 1/25/23 the Maintenance Supervisor/designee These finding were reviewed with the removed the desk assembly from Administrator and Maintenance Director at the the service hall; desk was approx. exit interview. 8 feet long and 3 feet wide being stored in the hallway to meet set 3.1-19(b)standards. The Administrator verified the work on 1/25/23. 2. Based on observation and interview, the facility **ALL OTHERS WITH** failed to ensure 1 of 5 corridor means of egress POTENTIAL TO BE AFFECTED: were continuously maintained free of All residents and all staff obstructions. This deficient practice affects 5 staff and visitors have the potential to in the Service Hall. be affected but none were. On 1/25/23 the Maintenance Findings include: Supervisor/designee inspected all corridor means of egress and

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Based on observation during a tour of the facility

with the Maintenance Director on 01/24/2023 at

2:55 pm in the Service Hall. There was a desk

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found no other negative findings.

MEASURES TO PREVENT

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--|--|---|---------------------|---|--|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | 524 AN | ADDRESS, CITY, STATE, ZIP COD NDERSON RD TERFIELD, IN 46017 | • |
| (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 |
| | assembly about 8 fe stored in the corrido stated that someone but had not done so This finding was rev | et long and 3 feet wide being or. The Maintenance Director was supposed to pick it up | | a. On 2/6/23 the Administration inserviced the Maintenance Supervisor/designee and all of staff on the requirement that the corridor means of egress are remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will insperate all corridor means of egress throughout the facility weekly obstructions as a part of the facility's Preventive Maintenant Program and document those inspection results as appropriate any issues are discovered, will be addressed and resolve immediately. The Maintenant 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 when the preventation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results when the Administrator will present the inspection results at the monton Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed | rator ther he to ect for nce ate. they do be ww vill ince a hly ce g. |
| | | | | the QA/PI Committee with | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) I | | | | SURVEY |
|--|--|---|-----------------------------------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPL | ETED |
| | | 155617 | B. Wl | ING | | 01/24/ | /2023 |
| N. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. | DOLUBED OF STREET | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DERSON RD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | CHESTERFIELD, IN 46017 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | | | | | subsequent plans of correction | | |
| | | | | | developed and implemented a deemed necessary to ensure | 15 | |
| | | | | | compliance is maintained. | | |
| | | | | | compilarios is maintaines. | | |
| | | | | | This plan of correction | | |
| | | | | | constitutes our credible | | |
| | | | | | allegation of compliance with | า | |
| | | | | | all regulatory requirements. | | |
| | | | | | Our date of compliance is | | |
| | | | | | February 16, 2023. | | |
| K 0222 | NFPA 101 | | | | | | |
| SS=D | Egress Doors | | | | | | |
| Bldg. 01 | Egress Doors | | | | | | |
| 2.49.0. | _ | d means of egress shall not | | | | | |
| | • | a latch or a lock that | | | | | |
| | | f a tool or key from the | | | | | |
| | | s using one of the following | | | | | |
| | special locking arr | angements: | | | | | |
| | CLINICAL NEEDS | OR SECURITY THREAT | | | | | |
| | LOCKING | | | | | | |
| | - | king arrangements for the | | | | | |
| | | eds of the patient are | | | | | |
| | | king device shall be | | | | | |
| | | door and provisions shall | | | | | |
| | | pid removal of occupants of locks; keying of all | | | | | |
| | _ | ed by staff at all times; or | | | | | |
| | | ed by stail at all tilles, of means available to the | | | | | |
| | staff at all times. | Thousand available to the | | | | | |
| | | 2.2.6, 19.2.2.2.5.1, | | | | | |
| | 19.2.2.2.6 | -,, | | | | | |
| | SPECIAL NEEDS | LOCKING | | | | | |
| | ARRANGEMENTS | | | | | | |
| | Where special locl | king arrangements for the | | | | | |
| | | e patient are used, all of | | | | | |
| | the Clinical or Sec | urity Locking requirements | | | | | |
| | | addition, the locks must be | | | | | |

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electrical locks that fail safely so as to

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--------------------------|---|--|-------|--|--|-------|---------------------------------------|--|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | | 524 ANI | NDDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | Ē | (X5) COMPLETION DATE | |
| | building is protect automatic sprinkle space is protected detection system at an attended loc space); and both it systems are arranupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed disystems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supedetection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRANACCESS-CONTRIBLE IN ACCESS-CONTRIBLE IN | ss LOCKING s lelayed-egress locking in accordance with permitted on door g low and ordinary hazard logs protected throughout by lervised automatic fire or an approved, supervised ler system. locked by locke | KO | 222 | K222 - It is the intent of the fac | ility | 02/16/2023 | |
| | failed to ensure 1 of | on and interview, the facility f 1 exit doors from the kitchen latching mechanism to release | K 02 | 222 | K222 - It is the intent of the factor to ensure exit doors from the kitchen only contain one latchi | | 02/16/2023 | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--|--|--|---------------------|---|----------------------------|
| | PROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | 524 AI | ADDRESS, CITY, STATE, ZIP COD NDERSON RD TERFIELD, IN 46017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION LSC 7.2.1.5.10 states a latch or | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) mechanism to release the do | DATE |
| | provided with a rele obvious method of operated under all li- states the releasing door leaf with not no operation. 7.2.1.5.1 | ce on a door leaf shall be taken as an operation and that is readily ghting conditions. 7.2.1.5.10.4 mechanism shall open the nore than one releasing 0.1 states the releasing | | and open to meet set standar 1. CORRECTIVE ACTION TAKEN: a. On 1/25/23 the Maintenance Supervisor/desiremoved one of the latching devices from the kitchen exit | gnee |
| | than 34 inches, and above the finished f could affect staff ex room. | latch shall be located not less not more than 48 inches, loor. This deficient practice iting the kitchen to the dining | | to meet set standards. The Administrator verified the wor 1/25/23. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta | ED: |
| | Director on 01/24/2 door was equipped latching door turn k lock. Based on inte observation, the Ma | on with the Maintenance 023 at 2:55 p.m., a kitchen exit with two latching devices, a nob and a separate deadbolt rview at the time of intenance Director agreed the as equipped with two latching | | and visitors have the potential be affected but none were. Of 1/25/23 the Maintenance Supervisor/designee inspected doors to the means of egress ensure they only contain one latching mechanism to releas door and found no other finding. MEASURES TO PREV REOCCURRENCE: | on d all to e the ngs. ENT |
| | | viewed with the Maintenance istrator during the exit | | a. On 2/6/23 the Administ inserviced the Maintenance Supervisor/designee on the requirement that exit doors for the kitchen only contain one latching mechanism to releas door and open to meet set standards. b. Maintenance Supervisor/designee will inspall means of egress throughofacility monthly to ensure exit doors from the kitchen only contain one latching mechanito release the door as a part of facility's Preventive Maintena | e the ect ut the sm of the |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DAT | | | (X3) DATE | SURVEY | | |
|--|---------------------|-------------------------------------|-------|------|-----------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | UILD | ING | 01 | COMPL | ETED |
| | | 155617 | B. W. | | | | 01/24 | |
| | | 133017 | ъ. W | UNU | | | 01/24/ | 2023 |
| | | | | S | TREET A | DDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | | DERSON RD | | |
| WATERS | S OF CHESTERFIE | ELD SKILLED NURSING FACILITY | | | | ERFIELD, IN 46017 | | |
| WAILING | O O CILCILITIE | LED SKILLED NONSING I ACILITI | | ľ | /IILOTI | LINI ILLD, IIN 40017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | I | D | DROWINED BY AN OF CODDECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PRE | EFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | | COMPLETION |
| TAG | · · | R LSC IDENTIFYING INFORMATION | | | AG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| 1110 | REGUERTORT OF | RESCRIPTION IN ORIGINATION | | | 710 | D | | DATE |
| | | | | | | Program and document those | | |
| | | | | | | inspection results as appropria | ate. | |
| | | | | | | If any issues are discovered, | | |
| | | | | | | they will be addressed and | | |
| | | | | | | resolved immediately. The | | |
| | | | | | | Maintenance Supervisor/desig | inee | |
| | | | | | | will review with the Administra | | |
| | | | | | | the inspection results. | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | monitor adherence to the | | |
| | | | | | | Preventative Maintenance | | |
| | | | | | | schedule and validate the | | |
| | | | | | | Preventative Maintenance | | |
| | | | | | | documentation is in place. | | |
| | | | | | | 4. MONITORING | | |
| | | | | | | CORRECTIVE ACTION: | | |
| | | | | | | a. The inspection results w | /ill | |
| | | | | | | · · · · · · · · · · · · · · · · · · · | | |
| | | | | | | be presented by the Maintena | nce | |
| | | | | | | Supervisor/designee to the | | |
| | | | | | | Administrator monthly and the | | |
| | | | | | | Administrator will present the | | |
| | | | | | | inspection results at the month | nly | |
| | | | | | | Quality Assurance/Performand | e | |
| | | | | | | Improvement (QA/PI) meeting | | |
| | | | | | | Inspection results and system | - | |
| | | | | | | components will be reviewed by | 3 V | |
| | | | | | | • | у | |
| | | | | | | the QA/PI Committee with | _ | |
| | | | | | | subsequent plans of correction | | |
| | | | | | | developed and implemented a | S | |
| | | | | | | deemed necessary to ensure | | |
| | | | | | | compliance is maintained. | | |
| | | | | | | | | |
| | | | | | | This plan of correction | | |
| | | | | | | constitutes our credible | | |
| | | | | | | | | |
| | | | | | | allegation of compliance with | ı | |
| | | | | | | all regulatory requirements. | | |
| | | | | | | Our date of compliance is | | |
| | | | | | | February 16, 2023. | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | | |
|--|--|--|------|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | | 524 ANI | ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | P | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| K 0223 SS=D Bldg. 01 | NFPA 101 Doors with Self-Cl Doors with Self-Cl Doors in an exit pay enclosure, or horizor hazardous area and kept in the cloopen by a release 7.2.1.8.2 that autor doors throughout entire facility upon * Required manua * Local smoke det smoke passing the required smoke det smoke passing the required smoke det * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2. Based on observation failed to ensure 1 of hazardous area encl in the closed position release device completicient practice completicient p | osing Devices osing Devices assageway, stairway contal exit, smoke barrier, a enclosure are self-closing used position, unless held device complying with matically closes all such the smoke compartment or activation of: If fire alarm system; and ectors designed to detect rough the opening or a etection system; and der system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 on and interview, the facility 2.2 kitchen exit doors to a osure are self-closing and kept on, unless held open by a olying with 7.2.1.8.2. This ould affect staff in the kitchen. Ons during a tour of the facility the Director on 01/24/2023 at the contained over 62 gallons of then a hazardous area. The from the dining room was a kick down door stop device when used would hold ot release if the fire alarm was a interview at the time of intenance Director agreed the open with this device that | K 02 | | K223 – It is the intent of the facility to ensure kitchen exit doors to a hazardous area enclosure are self-closing and kept in the closed position, un held open by a release device complying with 7.2.1.8.2 to me set standards. 1. CORRECTIVE ACTION TAKEN: a. On 1/25/23 the Maintenance Supervisor/desig removed the kick down door s installed on the door to the kitch from the dining room to meet standards. The Administrator verified the removal on 2/25/2. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. O | less eet S gnee top chen set 3. ED: ff to | 02/16/2023 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | | |
|--|---------------------|--|--|---------------|---|-------|--------------------|
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | | DERSON RD ERFIELD, IN 46017 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| | | viewed with the Administrator | | | 1/25/23 the Maintenance | | |
| | and Maintenance D | irector at the exit conference. | | | Supervisor/designee inspected | | |
| | 3.1-19(b) | | | | doors throughout the facility and found no other negative finding | | |
| | 3.1-17(0) | | | | 3. MEASURES TO PREVE | - | |
| | | | | | REOCCURRENCE: | | |
| | | | | | a. The Administrator will | | |
| | | | | | inservice Maintenance Superv & all staff on the requirements | | |
| | | | | | keep doors with self-closing | | |
| | | | | | devices in closed position or k | еер | |
| | | | | | them in open position with | o o t | |
| | | | | | approved release device to moset standards. | eeı | |
| | | | | | b. Maintenance | | |
| | | | | | Supervisor/designee will inspe | | |
| | | | | | all doors throughout the facility | / | |
| | | | | | monthly to ensure they have self-closing devices in closed | | |
| | | | | | position or keep them in the o | pen | |
| | | | | | position with approved release | | |
| | | | | | device as a part of the facility's | | |
| | | | | | Preventive Maintenance Progrand document those inspection | | |
| | | | | | results as appropriate. If any | | |
| | | | | | issues are discovered, they wi | | |
| | | | | | addressed and resolved | | |
| | | | | | immediately. The Maintenand Supervisor/designee will revie | | |
| | | | | | with the Administrator the | vv | |
| | | | | | 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: | /ill | |

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Facility ID: 000524

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | B NO. 0938-039 |
|--|--|--|---|--|-------------------------------|----------------|
| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction (| X3) DATE S COMPL 01/24/ | ETED |
| | PROVIDER OR SUPPLIER | LD SKILLED NURSING FACILIT | 524 AN | ADDRESS, CITY, STATE, ZIP COD NDERSON RD TERFIELD, IN 46017 | | |
| | 1 | | | TERM IEEE, IIV 40017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ON (X: DE COMPLE PRIATE DAT | |
| | | | | be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthl 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 February 16, 2023. | y e y | |
| K 0232 SS=E Bldg. 01 | unobstructed) ser at least 4 feet and convenient remov on stretchers, exc 19.2.3.4, exceptio 19.2.3.4, 19.2.3.5 | Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by ns 1-5. | | | | |
| | of 5 corridors clear | on, the facility failed to meet 1 width requirement per 19.2.3.4. res the width of aisles and | K 0232 | K232 – It is the intent of the faci to ensure to meet the corridors clear width requirement per | - | 02/16/2023 |

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corridors (clear and unobstructed) serving as exit

provide the convenient removal of nonambulatory

access shall be at least 4 feet and maintained to

patients on stretchers, except as modified by

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TAKEN:

On 1/25/23 the

19.2.3.4 to meet set standards.

1. CORRECTIVE ACTIONS

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155617 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 01 | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|---|--|---|---------------------|---|---|
| | ROVIDER OR SUPPLIEF | LD SKILLED NURSING FACILITY | 524 AN | ADDRESS, CITY, STATE, ZIP COD NDERSON RD FERFIELD, IN 46017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | (X5) COMPLETION DATE |
| | REGULATORY OF 19.2.3.4, exceptions could affect about t Findings include: Based on observation Director on 01/24/2 exit #3, a wooden tabehind was position access corridor. On there was a line of table a 3 foot walking interview at the tim Maintenance Direct normally out so far This finding was re | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION IS 1-5. This deficient practice wo staff and seven residents. On with the Maintenance R3 at 2:15 p.m., in the corridor to able that a resident was sitting ned on one side of the exit the other side of the corridor residents in wheelchairs. This g area in the corridor. Based on the of observation, the tor, said that the desk was not | | Maintenance Supervisor/des removed the wooden table in corridor to exit #3 to meet se standards. The Administrator verified the removal on 1/25/2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. 1/25/23 the Maintenance Supervisor/designee inspect corridors throughout the faciliensure no items were being improperly and reducing the of the corridor and found no negative findings. 3. MEASURES TO PREV. REOCCURRENCE: a. On 2/6/23 the Administinserviced the Maintenance Supervisor/designee on the requirement that no items are be stored in corridors which is reduce the corridor width to reset standards. b. On 2/10/23 the Administrator inserviced all contents are to be stored in corriwidation to set standards. c. Maintenance Supervisor/designee will inspall exit access corridors throughout the facility weekly ensure no items are being st in the corridors which would reduce the corridor width as | ignee in the st or 23. FED: aff all to On ed all lity to stored width other /ENT strator e to would meet other no ridors idor stored or ored |
| | | | | of the facility's Preventive | ~ F~., |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | | SURVEY | | |
|--|----------------------|---|------------------------------|--------|---|------------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPLE | | | ETED | |
| | | 155617 | B. W | ING | | 01/24 | /2023 |
| | | | | | _ | | |
| NAME OF F | PROVIDER OR SUPPLIEI | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | IDERSON RD | | |
| WATERS | OF CHESTERFIE | ELD SKILLED NURSING FACILITY | | CHEST | ERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | Maintenance Program and | | |
| | | | | | document those inspection re- | sults | |
| | | | | | as appropriate. If any issues | are | |
| | | | | | discovered, they will be addre | ssed | |
| | | | | | and resolved immediately. Th | ie | |
| | | | | | Maintenance Supervisor/desig | gnee | |
| | | | | | will review with the Administra | will review with the Administrator | |
| | | | | | the inspection results. | | |
| | | | | | d. 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 v | vill | |
| | | | | | be presented by the Maintena | | |
| | | | | | Supervisor/designee to the | | |
| | | | | | Administrator monthly and the | | |
| | | | | | Administrator will present the | | |
| | | | | | inspection results at the month | nly | |
| | | | | | Quality Assurance/Performan | - | |
| | | | | | Improvement (QA/PI) meeting | | |
| | | | | | Inspection 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 | | |
| | | | | | February 16, 2023. | | |

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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 01/24/2023 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0291 **NFPA 101** SS=F **Emergency Lighting** Bldg. 01 **Emergency Lighting** Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1. 19.2.9.1 Based on records review, observation, and K 0291 02/16/2023 K291 - It is the intent of the interview, the facility failed to ensure battery facility to ensure battery backup backup lights were tested monthly. Section lights are tested monthly to meet 7.9.3.1.1 (1) requires functional testing shall be set standards. conducted monthly, with a minimum of 3 weeks 1.CORRECTIVE ACTIONS and a maximum of 5 weeks between tests, for not TAKEN: less than 30 seconds and (5) Written records of 1.On 1/18/23 the visual inspections and tests shall be kept by the Maintenance Supervisor/designee owner for inspection by the authority having conducted the monthly 30 second jurisdiction. This deficient practice could affect all test for the battery powered residents of the facility. emergency lights and documented the results on the Findings include: **Battery-Operated Emergency** Lights and signs Test Log to meet Based on records review on 01/24/2023 at 10:40 set standards. The Administrator a.m., documentation of the monthly 30 second test verified the work on 1/25/23. for the battery powered emergency lights 2.ALL OTHERS WITH indicated that from July through December of 2022 POTENTIAL TO BE AFFECTED: there was no record of completion. Based on 1.All residents and all staff interview at the time of record review and and visitors have the potential to observation, the Maintenance Director confirmed be affected but none were. there was no documentation of the test being **3.MEASURES TO PREVENT** done July through December of 2022. REOCCURRENCE: 1.On 2/6/23 the This finding was reviewed with the Administrator Administrator inserviced the and Maintenance Director during the exit Maintenance Supervisor/designee conference. on the requirement to provide and maintain emergency lighting to 3.1-19(b) meet set standards.

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2.Maintenance

Supervisor/designee will conduct the 30-second monthly test as a part of the facility's Preventive

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
|--|----------------------|--|---------------------|---|----------------------------------|
| | PROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | 524 AN | ADDRESS, CITY, STATE, ZIP COD IDERSON RD ERFIELD, IN 46017 | |
| (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 |
| | | | | Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and maintain emergency lighting to meet set standards. If any issues are discovered, they waddressed and resolved immediately. The Maintenand Supervisor/designee will reviewith 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 ACTION: 1. The inspection results be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. | IVE Will nce hly ce by nas |

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| | OF HEALTH AND HUM | | | | | | | 02/28/2023 ROVED 938-039 |
|---|---|--|-------------------------------------|----------------|--|--------------------------------|------|--------------------------------|
| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | ľ í | JILDING ING | INSTRUCTION 01 | (X3) DATE : COMPL 01/24/ | ETED | |
| NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACIL (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION | | | | 524 AN | ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | | |
| PREFIX | ID SUMMARY STATEMENT OF DEFICIENCIE FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOU | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMP | (X5) PLETION ATE |
| K 0321 SS=D Bldg. 01 | barrier having 1-ho (with 3/4 hour fire | - Enclosure are protected by a fire our fire resistance rating | | | Our date of compliance is February 16, 2023. | | | |

accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in

REMARKS. 19.3.2.1, 19.3.5.9

Area Automatic Sprinkler

Separation N/A

- a. Boiler and Fuel-Fired Heater Rooms
- b. Laundries (larger than 100 square feet)
- c. Repair, Maintenance, and Paint Shops
- d. Soiled Linen Rooms (exceeding 64
- gallons)
- e. Trash Collection Rooms (exceeding 64 gallons)
- f. Combustible Storage Rooms/Spaces
- (over 50 square feet)
- g. Laboratories (if classified as Severe

Hazard - see K322)

Based on observation and interview, the facility failed to ensure 1 of 2 laundry corridor doors,

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K 0321

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K321- It is the intent of the facility

to ensure laundry corridor doors,

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 01/24/2023 | | | |
|--|--|--|----------------------------------|----------------------|---|-------|------------|--|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | _ | 524 AN | ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | - | | |
| WATERO | OF CHECKEN | ED GRIELED NORGING I AGILITI | | CITEOT | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | is area greater than 100 square | | | which is a hazardous area gre | | | |
| | - | with a self-closing device | | | than 100 square feet, is provide | | | |
| | | the door to automatically | with a self-closing device which | | | h | | |
| | | the door frame. This deficient | would cause the door to | | | | | |
| | practice could affect | t staff in the service hall. | | | automatically close and latch | into | | |
| | P' 1' ' 1 1 | | | | the door frame to meet set | | | |
| | Findings include: | | | | standards. | _ | | |
| | D 1 1 4 | | | 1. CORRECTIVE ACTION | S | | | |
| | Based on observations during a tour of the facility | | | | TAKEN: | | | |
| | with the Maintenance Director on 01/24/23 at 2:45 | | | | a. On 1/25/23 the | | | |
| | p.m., the laundry room, a hazardous storage room | | | | Maintenance Supervisor/desig | • | | |
| | that was greater than 100 square feet, was | | | | repaired the laundry room doo | | | |
| | equipped with self-closing device on the soiled linen corridor door but did not latch into the frame | | | | ensure it latches into the door | | | |
| | | | | | frame to meet set standards. | | | |
| | | on interview at the time of | | | Administrator verified the worl | con | | |
| | | intenance Director agreed the | | | 1/25/23. | | | |
| | | in 100 square feet, and stated | | | 2. ALL OTHERS WITH | | | |
| | the door did not late | ch into the frame. | | | POTENTIAL TO BE AFFECT | | | |
| | TT1: (* 1: | | | | a. All residents and all sta | | | |
| | | viewed with the Administrator | | | and visitors have the potential | | | |
| | and Maintenance Di | irector at the exit conference. | | | be affected but none were. O | n | | |
| | 2.1.10(1.) | | | | 1/25/23 the Maintenance | | | |
| | 3.1-19(b) | | | | Supervisor/designee inspecte | | | |
| | | | | | hazardous areas for self-closi | • | | |
| | | | | | devices and latch into the doc | | | |
| | | | | | frame and found no other neg findings. | auve | | |
| | | | | | 3. MEASURES TO PREVI | ENT | | |
| | | | | | REOCCURRENCE: | -IN I | | |
| | | | | | a. On 2/6/23 the Administr | ator | | |
| | | | | | inserviced the Maintenance | atoi | | |
| | | | | | Supervisor/designee on the | | | |
| | | | | | requirement that all hazardous | 2 | | |
| | | | | | areas must have self-closing | • | | |
| | | | | | devices and latch into the doc | r | | |
| | | | | | frame to meet set standards. | • | | |
| | | | | | b. Maintenance | | | |
| | | | | | Supervisor/designee will inspe | ect | | |
| | | | | | all hazardous area doors | | | |
| | | | | | throughout the facility monthly | , to | | |

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| | OF CORRECTION | IDENTIFICATION NUMBER 155617 | A. BUILDING B. WING | 01 | COMPLETED 01/24/2023 |
|--------------------------|---------------------|--|---------------------|--|---|
| | ROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | 524 AN | ADDRESS, CITY, STATE, ZIP COD NDERSON RD FERFIELD, IN 46017 | |
| (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 |
| | | | | ensure they have self-closing devices and latch into the doo frame as a part of the facility's Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they winderessed 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 which be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented and deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. | ram on ill be se w vill nce shly ce l. by n as |

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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 01 155617 B. WING 01/24/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Our date of compliance is February 16, 2023. K 0345 **NFPA 101** SS=F Fire Alarm System - Testing and Bldg. 01 Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility K 0345 K345- It is the intent of the facility 02/16/2023 failed to ensure 1 of 1 fire alarm systems was to ensure fire alarm systems are maintained in accordance with 9.6.1.3. LSC 9.6.1.3 maintained in accordance with requires a fire alarm system to be installed, tested, 9.6.1.3 to meet set standards. and maintained in accordance with NFPA 70, 1. **CORRECTIVE ACTIONS** National Electrical Code and NFPA 72, National TAKEN: Fire Alarm Code. This deficient practice could On 9/6/22 a licensed fire affect all occupants. alarm contractor/designee conducted the annual fire alarm Findings include: inspection and the semiannual visual inspection and retained Based on record review and interview with the documentation in the facilities Life Maintenance Director on 01/24/2023 at 10:30 a.m., Safety Binder to meet set the annual fire alarm inspection report was not standards. The Administrator available for review. There was a semi-annual verified the work on 1/25/23. visual inspection done on 03/04/2022 but no **ALL OTHERS WITH** documentation of an annual inspection completed **POTENTIAL TO BE AFFECTED:** six months later. Based on interview at the time of All residents and all staff

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of the survey.

record review, the Maintenance Director stated

that he would call the service provider to fax a

documentation was not provided before the end

copy of the inspection report but the

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and visitors have the potential to

MEASURES TO PREVENT

On 2/6/23 the Administrator

be affected but none were.

inserviced the Maintenance

REOCCURRENCE:

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>01</u> | COMP | E SURVEY PLETED 4/2023 |
|--------------------------|-----------------------------------|---|--|--|---|------------------------------|
| | PROVIDER OR SUPPLIE | R ELD SKILLED NURSING FACILIT | 524 AN | ADDRESS, CITY, STATE, ZIP CO NDERSON RD FERFIELD, IN 46017 | DD | |
| (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 CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY) | ECTION DULD BE PROPRIATE | (X5) COMPLETION DATE |
| IAG | This finding was re | eviewed with the Administrator Director at the exit conference. | TAG | Supervisor/designee on requirement that fire ala systems must be mainta accordance with 9.6.1.3 annual testing and semivisual inspections on the system must be perform meet set standards. b. Maintenance Supervisor/designee will fire alarm systems are rand annual testing and semi-annual visual insperformed as a part of the Preventive Maintenance and document those instresults as appropriate. It issues are discovered, the addressed and resolved immediately. The Maintenance and document those instresults as appropriate. In the Administrator the inspection results. In the Administrator the inspection results. In the Administrator the inspection results. In the Administrator the inspection results and solve the Maintenance and validate the preventative maintenance and validat | ained in a and i-annual e fire alarm ned to are to | DATE |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155617 | | ĺ | ILDING | nstruction <u>01</u> | (X3) DATE S COMPL 01/24/ | ETED | |
|---|---|--|--------|-------------------------|--|--------|----------------------------|
| | PROVIDER OR SUPPLIER | LD SKILLED NURSING FACILITY | | 524 ANI | DDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017 | | |
| (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 0347 SS=E Bldg. 01 | | systems are provided in pridors as required by | | | components will be reviewed by 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 February 16, 2023. | n s | |
| | failed to ensure 1 of installed in accordant requires a fire alarm and maintained in a National Electrical Fire Alarm Code. A smoke detectors to proverage that shall is storage areas, basen suspended ceilings, accessible spaces, acclosets, elevator shall dumbwaiter shafts, | on and interview, the facility If fire alarm systems was nee with 19.3.4.1. LSC 9.6.1.3 It system to be installed, tested, recordance with NFPA 70, Code and NFPA 72, National NFPA 72, 17.5.3.1 requires provide total (complete) include all rooms, halls, ments, attics, spaces above and other subdivions and is well as the inside of all offs, enclosed stairways, and chutes. This deficient to 10 residents in one smoke | K 03 | 347 | K347– It is the intent of the facto ensure fire alarm systems at installed in accordance with 19.3.4.1 to meet set standards 1) CORRECTIVE ACTIONS TAKEN: a) On 2/14/23 a licensed sprinkler system contractor was contacted to install smoke detectors in the library, by the Activity room to meet set standards. The Administrator verified the quote on 2/14/23. smoke detector is scheduled to installed by 2/24/23. 2) ALL OTHERS WITH POTENTIA/L TO BE AFFECTE a) All residents and all staff | The be | 02/24/2023 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|-----------------------|---------------------------------|-----------------------|----------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> | | COMPLETED | | |
| | | 155617 | B. WING | | | 01/24/20 | 023 |
| NAME OF DROVIDED OR CURRI IED | | | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | DERSON RD | | |
| WATERS OF CHESTERFIELD SKILLED NURSING FACILITY | | | | CHEST | ERFIELD, IN 46017 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE (| COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | | 4- | DATE |
| | Rased on observation | on with the Maintenance | | | and visitors have the potential be affected but none were. O | | |
| | | 3 at 2:15 p.m., in the library, | | | 1/25/23 the Maintenance | [] | |
| | | by the Activity room there | | | Supervisor/designee inspected | d all | |
| | - | noke detection. Based on | | | other areas for proper smoke | | |
| | | e of observation, the | | | detector coverage and found r | no | |
| | Maintenance Direct | or stated there was no smoke | | | other negative findings. | | |
| | detector in this area | | | | 3) MEASURES TO PREVE | NT | |
| | | | | | REOCCURRENCE: | | |
| | _ | viewed with the Administrator | | | a) On 2/6/23 the Administr | ator | |
| | | irector during the exit | | | inserviced the Maintenance | | |
| | conference. | | | | Supervisor/designee on the | | |
| | 2 1 10/4) | | | | requirement that areas must b | е | |
| | 3.1-19(b) | | | | provided with proper smoke | d in | |
| | | | | | detector coverage and installe accordance with 19.3.4.1 to m | I | |
| | | | | | set standards. | leet | |
| | | | | | b) Maintenance | | |
| | | | | | Supervisor/designee will inspe | ect | |
| | | | | | all areas throughout the facility | | |
| | | | | | monthly for proper smoke dete | | |
| | | | | | coverage as a part of the facili | ity's | |
| | | | | | Preventive Maintenance Prog | ram | |
| | | | | | and document those inspectio | I | |
| | | | | | results as appropriate. If any | | |
| | | | | | issues are discovered, they wi | ill be | |
| | | | | | addressed and resolved | _ | |
| | | | | | immediately. The Maintenand | I | |
| | | | | | Supervisor/designee will revie with the Administrator the | vv | |
| | | | | | 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 v | vill | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTERS FOI | R MEDICARE & MEDIC | AID SERVICES | | | OMB NO. 0938-039 |
|---|--------------------|---|-------------------------|--|--------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> 155617 B. WING | | <u>01 </u> | COMPLETED 01/24/2023 | | |
| | | 133017 | | | 01/24/2023 |
| NAME OF PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD IDERSON RD | |
| WATERS | S OF CHESTERFIE | LD SKILLED NURSING FACILIT | | ERFIELD, IN 46017 | |
| | 1 | | | I | (1/5) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE |
| | | | | be presented by the Maintenar | |
| | | | | Supervisor/designee to the | |
| | | | | Administrator monthly and the | |
| | | | | Administrator will present the | |
| | | | | inspection results at the month | - |
| | | | | Quality Assurance/Performanc Improvement (QA/PI) meeting. | |
| | | | | Inspection results and system | |
| | | | | components will be reviewed b | y |
| | | | | the QA/PI Committee with | |
| | | | | subsequent plans of correction | |
| | | | | developed and implemented as | S |
| | | | | 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 February 24, 2023. | |
| | | | | February 24, 2023. | |
| K 0353 | NFPA 101 | | | | |
| SS=C | 1 ' | - Maintenance and Testing | | | |
| Bldg. 01 | · · | - Maintenance and Testing | | | |
| | | er and standpipe systems | | | |
| | ' ' | ted, and maintained in NFPA 25, Standard for the | | | |
| | | g, and Maintaining of | | | |
| | 1 | Protection Systems. | | | |
| | | n design, maintenance, | | | |
| | 1 | sting are maintained in a | | | |
| | | nd readily available. | | | |
| | a) Date sprinkler | system last checked | | | |
| | l ———— | system test | 1 | | |

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c) Water system supply source

Provide in REMARKS information on

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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 01/24/2023 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (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 coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility K 0353 K353 - It is the intent of the 02/16/2023 failed to ensure 1 of 4 sprinkler system gauges facility to ensure sprinkler system were replaced every 5 years or documented as gauges are replaced every 5 years tested every 5 years by comparison with a or documented as tested every 5 calibrated gauge. NFPA 25, Standard for the years by comparison with a Inspection, Testing, and Maintenance of calibrated gauge to meet set Water-Based Fire Protection Systems, 2011 standards. Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by 1.CORRECTIVE ACTIONS comparison with a calibrated gauge. Gauges not TAKEN: accurate to within 3 percent of the full scale shall 1.On 1/29/23 a Licensed be recalibrated or replaced. This deficient practice Sprinkler Contractor/Maintenance could affect all residents, staff, and visitors in the Supervisor/designee replaced the facility. pressure gauge that was dated 2017 to meet set standards. The Findings include: Administrator verified the work on 1/29/23. Based on observations during a tour of the facility 2.ALL OTHERS WITH with the Maintenance Director on 01/24/23 at 2:35 POTENTIAL TO BE AFFECTED: p.m. the facility has supervised dry sprinkler 1.All residents and all staff systems with four pressure gauges, one of the and visitors have the potential to pressure gauges was dated 2017. No recalibration be affected but none were. **3.MEASURES TO PREVENT** date information was affixed to the sprinkler system gauge. Based on interview at the time of REOCCURRENCE: the observations, the Maintenance Director 1.On 2/6/23 the agreed it was older than five years. Administrator inserviced the Maintenance Supervisor/designee This finding was reviewed with the Administrator on the requirement that the and Maintenance Director at the exit conference. sprinkler system must be properly

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3.1-19(b)

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maintained to meet set standards.

2.Maintenance Supervisor/designee will ensure the sprinkler systems are maintained and the pressure gauges are tested or replaced every 5 years as a part of the facility's Preventive Maintenance

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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. BUILDING <u>01</u> | | COMPLETED | | |
| | | 155617 | B. WING | | | 01/24/2023 | |
| | | | | _ | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | DERSON RD | | |
| WATERS | OF CHESTERFIE | LD SKILLED NURSING FACILITY | | CHEST | ERFIELD, IN 46017 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | DROVIDERIC DI ANI OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHO | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | T- | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE |
| | | | | | Program and document those | | |
| | | | | | inspection results as appropria | ate. | |
| | | | | | If any issues are discovered, t | | |
| | | | | | will be addressed and resolve | - | |
| | | | | | immediately. The Maintenance | | |
| | | | | | Supervisor/designee will revie | | |
| | | | | | 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. | VE | |
| | | | | | 4.MONITORING CORRECT | VE | |
| | | | | | ACTION: | :11 | |
| | | | | | 1.The inspection results v | | |
| | | | | | be presented by the Maintena | nce | |
| | | | | | Supervisor/designee to the | | |
| | | | | | Administrator monthly and the | | |
| | | | | | Administrator will present the | | |
| | | | | | inspection results at the month | - | |
| | | | | | Quality Assurance/Performand | | |
| | | | | | Improvement (QA/PI) meeting | | |
| | | | | | Inspection results and system | | |
| | | | | | components will be reviewed I | ру | |
| | | | | | the QA/PI Committee with | | |
| | | | | | subsequent plans of correction | | |
| | | | | | developed and implemented a | S | |
| | | | | | deemed necessary to ensure | | |
| | | | | | compliance is maintained. | | |
| | | | | | | | |
| | | | | | This plan of correction | | |
| | | | | | constitutes our credible | | |
| | | | | | allegation of compliance witl | า | |
| | | | | | all regulatory requirements. | | |
| | | | | | Our date of compliance is | | |
| | | | | | February 16, 2023. | | |

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| ì ´ | | (X2) MULTIPLE CONSTRUCTION A BUILDING 01 | | | (X3) DATE SURVEY | | |
|--|------------------------|---|---|--------|--|-------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> B. WING | | <u>U1</u> | COMPLETED 01/24/2023 | |
| | | 155617 | B. WING | | | U1/24, | 12023 |
| NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY | | | STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017 | | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| K 0500 | NFPA 101 | | | | | | |
| SS=D | Building Services | - Other | | | | | |
| Bldg. 01 | Building Services | - Other | | | | | |
| | List in the REMAR | RKS section any LSC | | | | | |
| | Section 18.5 and 1 | 19.5 Building Services | | | | | |
| | - | are not addressed by the | | | | | |
| | | out are deficient. This | | | | | |
| | | with the applicable Life | | | | | |
| | • | FPA standard citation, | | | | | |
| | | d on Form CMS-2567. | | | | | |
| | | on and interview, the facility | K 0 | 500 | K500- It is the intent of the fac | • | 03/15/2023 |
| | | f 2 fuel fired boilers had current | | | to ensure fuel-fired boilers have | | |
| | _ | es to ensure the water heaters | | | current inspection certificates | | |
| | • | ng condition. NFPA 101, | | | ensure the water heaters are i | | |
| | | equires all health facilities to be | | | safe operating condition to me | et | |
| | _ | d, maintained and operated to | | | set standards. | _ | |
| | _ | pility of a fire emergency | | | 1. CORRECTIVE ACTION | S | |
| | | ation of occupants. This | | | TAKEN: | | |
| | - | ould affect staff in the | | | a. A Certified Water Heate | | |
| | mechanical room vi | cinity. | | | Inspector is scheduled to insp | | |
| | Findings include: | | | | the two boilers in the mechani room and provide the facility w Certificates of Inspection to m | /ith | |
| | Based on record rev | riew and observation during a | | | set standards. The Administra | ator | |
| | tour of the facility w | vith the Maintenance Director | | | verified that the inspection is | | |
| | | p.m., the two boilers in the | | | scheduled to be completed by | | |
| | | d not have documentation to | | | 3/15/23. | | |
| | | e inspected within the last two | | | 2. ALL OTHERS WITH | | |
| | | erview at the time of the | | | POTENTAL TO BE AFFECTE | | |
| | | intenance Director stated the | | | a. All residents and all stat | - | |
| | - | ntation for the boilers could | | | and visitors have the potential | | |
| | not be found. | | | | be affected but none were. The | ne | |
| | TTI: C' 1: | | | | facility has only four water | | |
| | | viewed with the Administrator | | | heaters. | | |
| | and Maintenance Di | irector at the exit conference. | | | 3. MEASURES TO PREVE | :NT | |
| | 2.1.10(%) | | | | REOCCURRENCE: | _4 | |
| | 3.1-19(b) | | | | a. On 2/6/23 the Administr | ator | |
| | | | | | inserviced the Maintenance | | |
| | | | | | Supervisor/designee on the | | |
| | | | l | | requirement that fuel-fired boil | ers | 1 |

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>01</u> | COME | e survey Pleted 4/2023 |
|--------------------------|------------------------------------|---|--|---|---|------------------------------|
| | ROVIDER OR SUPPLIE | R ELD SKILLED NURSING FACILIT | 524 AN | ADDRESS, CITY, STATE, ZIP CO IDERSON RD FERFIELD, IN 46017 | DD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY) | ECTION OULD BE PPROPRIATE | (X5) COMPLETION DATE |
| | | | | must be inspected and a Certificate of Inspection the facility to meet set sib. Maintenance Supervisor/designee wil fuel-fired boilers annuall they are inspected and documentation retained facility as a part of the farewentive Maintenance and document those insignees are discovered, the addressed and resolved immediately. The Maintenance issues are discovered, the addressed and resolved immediately. The Maintenance issues are discovered, the addressed and resolved immediately. The Maintenance is maintenance in the Administrator the inspection results. The Administrator the inspection results and validate the Preventative Maintenance is in placed. Monitoring Corrective Action a. The inspection rebe presented by the Macsupervisor/designee to Administrator will presert inspection results at the Quality Assurance/Performent (QA/PI) monitoring inspection results and second implement the QA/PI Committee with the QA/PI Committee with subsequent plans of condeveloped and implement deemed necessary to element. | Il check all ly to ensure I at the acility's e Program spection If any they will be detenance ll review he | |

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| | Γ OF HEALTH AND HU R MEDICARE & MEDIC | | | | | ORM APPROVED MB NO. 0938-039 | |
|---|---|---|---------------------|---|---|---------------------------------------|--|
| | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING | | | | COM | (X3) DATE SURVEY COMPLETED 01/24/2023 | |
| NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACIL (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION K 0927 SS=D Bldg. 01 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable | 524 | EET ADDRESS, CITY, STATE, ZIP CO ANDERSON RD ESTERFIELD, IN 46017 | OD | | | | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | ID PREFIX TAG | CROSS-REFERENCED TO THE A | HOULD BE | (X5) COMPLETION DATE | |
| | | | | This plan of correction constitutes our credib allegation of compliar all regulatory requirer Our date of compliance March 15, 2023. | n ble nce with nents. | | |
| SS=D | Gas Equipment - Gas Equipment - Transfilling of oxy another is in accordance Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen oc containers over 5 under 11.5.2.3.1 liquid oxygen con containers under conditions under 11.5.2.2 (NFPA 9 | Transfilling Cylinders gen from one cylinder to ordance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is ent care rooms. Transfilling ontainers or to portable 0 psi comply with conditions (NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) | V 0027 | K027. It is the intent of | f the feeility | 02/16/2022 | |
| | failed to ensure 1 of location was used p with NFPA 99. NF Code, 2012 Edition (transfilling shall of separated from any | on and interview, the facility f 1 oxygen storage/transfer properly and in accordance PA 99, Health Care Facilities a, Section 11.5.2.3.1(1) states, ccur in) A designated area portion of a facility wherein , examined, or treated by a fire | K 0927 | k927– It is the intent of to ensure oxygen storal location is used proper accordance with NFPA set standards. 1.CORRECTIVE ACT TAKEN: a. On 2/10/23 the | age/transfer ly and in a 99 to meet | 02/16/2023 | |

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Findings include:

barrier of 1 hour fire-resistive construction. This

deficient practice could affect all staff in the

Based on observation with the Maintenance

Service Hall smoke compartment.

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Administrator/DON inserviced all

nursing staff on the proper way to

use transfilling room and to ensure the door is closed while transfilling

is occurring to meet set standards. The Administrator

verified this on 2/10/23.

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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 01 COMPLETED 155617 B. WING 01/24/2023

| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD | | | | |
|---|--|--------------------------------------|------------------------|--|------------|--|
| | | 524 ANDERSON RD | | | | |
| WATERS OF CHESTERFIELD SKILLED NURSING FACILITY | | | CHESTERFIELD, IN 46017 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETION | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE | |
| | Director during a tour of the facility at 2:50 p.m. on | | | b. On 1/26/23 the DON | | |
| | 01/24/23 the oxygen storage/transfer room on the | | | removed the additional oxygen | | |
| | Service Hall of the facility was used by a male | | | tanks from the transfilling room so | | |
| | employee. The employee entered the oxygen | | | the door is able to be closed while | | |
| | transfilling room, held the door open with his leg, | | | transfilling is occurring to meet set | | |
| | and placed the portable oxygen unit on the | | | standards. The Administrator | | |
| | oxygen tank, and began to transfer oxygen from | | | verified this on 1/27/23. | | |
| | the main tank to the portable oxygen tank while he | | | 1.ALL OTHERS WITH | | |
| | was holding the door to the corridor open. Based | | | POTENTAL TO BE AFFECTED: | | |
| | on interview at the time of the observation, the | | | 1.All residents and all staff | | |
| | employee was asked if this was the normal | | | and visitors have the potential to | | |
| | procedure for transferring oxygen to a portable | | | be affected but none were. | | |
| | oxygen tank, and he said it was not. The employee | | | 2.MEASURES TO PREVENT | | |
| | stated that there is normally enough room to close | | | REOCCURRENCE: | | |
| | the door before transfilling but there were too | | | a. On 2/10/23 the DON/designee | | |
| | many tanks in the oxygen room to allow him to go | | | will monitor the oxygen transfilling | | |
| | inside and close the door. | | | procedures to ensure all nursing | | |
| | | | | staff is meeting set requirements | | |
| | This finding was reviewed with the Administrator | | | per our Oxygen Policy & | | |
| | and Maintenance Director at the exit conference. | | | Procedures to meet set | | |
| | | | | standards. | | |
| | 3.1-19(b) | | | b. The DON will ensure the | | |
| | | | | Oxygen Storage Room has | | |
| | | | | enough space to allow the door to | | |
| | | | | be closed while transfilling is | | |
| | | | | occurring as a part of the facility's | | |
| | | | | Oxygen Storage Room Policy & | | |
| | | | | Procedures 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 Oxygen Policy & | | |
| | | | | Procedure and validate the | | |
| | | | | Preventative Maintenance | | |
| | | I | | degumentation is in place | 1 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

62V221

Facility ID: 000524

documentation is in place.

If continuation sheet

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP of 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) STREET ADDRESS, CITY, STATE, ZIP of 524 ANDERSON RD CHESTERFIELD, IN 46017 PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION STATEMENT) | COD |
|--|--|
| PROVIDER'S PLAN OF CO PRETY (FACH DEFICIENCY MIST BE PRECEDED BY FILL I PREFIX (EACH CORRECTIVE ACTION): (EACH DEFICIENCY MIST BE PRECEDED BY FILL I PREFIX (EACH CORRECTIVE ACTION): | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 1.MONITORING CO ACTION: 1.The inspection be presented by the D and the Administrator the inspection results monthly Quality Assurance/Performan Improvement (QA/PI) Inspection results and components will be re the QA/PI Committee subsequent plans of o developed and impler deemed necessary to compliance is maintai This plan of correctic constitutes our credi allegation of complia all regulatory require Our date of complian February 16, 2023. | COMPLETION DATE COMPLE |

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