STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING -- B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/05/24 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Emergency Preparedness survey, The Waters of Hobart Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 110 certified beds. At the time of the survey, the census was 49. Quality Review completed on 08/07/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/05/2024 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Life Safety Code survey, The Waters of	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	Executive Director	08/22/2024

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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	Hobart Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. A later one story addition, consisting of the east wing constructed prior to March 2003, determined to be Type V (111) was also fully sprinklered, therefore it was surveyed as one building in accordance with LSC Chapter 19. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. Battery powered smoke detectors are installed in all resident rooms. The building is partially protected by a 230 kW diesel powered emergency generator. The facility has the capacity for 110 and had a census of 49 at the time of this survey. Quality Review completed on 08/07/24			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 maintenance storage room. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., in the suspended ceiling the maintenance storage room had a drop ceiling which was missing a tile exposed the ceiling about approximately one foot. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observation, the Environmental Director confirmed that the ceiling tile was missing and further stated that she was unaware how long the tile had been missing. The finding was reviewed with the Executive Director during the exit conference.	K 0353	**K353** – It is the intent of the facility to ensure to maintain the ceiling construction of the maintenance storage room and to ensure to maintain the ceiling construction in the bathroom of resident room 151/153 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 08/06/2024 the Maintenance Supervisor installed the missing ceiling tile in the maintenance storage room to meet set standards. The Administrator verified the work on 08/06/2024. 2.On 08/06/2024 the Maintenance Supervisor repaired the angular space with a one hour fire rated material in the shared bathroom for resident rooms 151 and 153 to meet set standards. The Administrator verified the work on 08/06/2024 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were.	08/22/2024

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	3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in the bathroom of resident room 151/153. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observation with the Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., in the ceiling of the shared bathroom for resident rooms 151 and 153 had one sprinkler head which had annular space measuring approximately one-eighth inch in diameter. Based on interview at the time of observation, the Environmental Director acknowledged the annular space and further stated that she will get the process started to fix the issues. The finding was reviewed with the Executive Director at exit conference. 3.1-19(b)		**3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 08/06/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure all ceiling tiles are present and there are no annular spaces around the sprinkler heads to meet set standards. 2.Maintenance Supervisor/designee will ensure all ceiling tiles are present and there are no annular spaces around the sprinkler heads monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 08/06/2024**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 medicine room doors for central wing to the corridor would completely resist the passage of smoke. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 0363	**K363** – It is the intent of the facility to ensure medicine room doors for central wing to the corridor would completely resist the passage of smoke and to ensure medicine room corridor door on the central wing are provided with a means suitable for keeping the door closed, have no impediment to closing, latching and would resist the page of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 08/06/2024 the Maintenance Supervisor/designee sealed the penetration on the door to the central nurse's station medicine room with a one hour fire rated material to meet set standards. The Administrator verified the repairs on 08/06/2024	08/22/2024

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	impediment for the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or flames in window assemblies. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation on 08/05/24 between 10:54 a.m. and 12:19 p.m. during a tour of the facility with the Environmental Director, the door to the central nurse's station medicine room had an approximate one-quarter inch circular shaped hole above the door handle to the door that opened to the corridor. Based on interview at the time of observation, the Environmental Director confirmed that the door had a penetration and would get that addressed before the end of the day. The penetration was sealed by the end of the survey. The finding was reviewed with the Environmental Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 medicine room corridor door on the central wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist		. b On 08/06/2024 the Maintenance Supervisor/designee removed the tape from the crash plate on the door to the medicine room in the central wing nurse's station to ensure the door closes and latches into the frame to meet set standards. The Administrator verified the repairs on 08/06/2024. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all doors and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 08/06/2024 the Administrator in serviced the Maintenance Supervisor/Nursing Staff/Don on the requirement to provide corridor doors that would resist the passage of smoke with no penetrations and doors that would close completely and latch into the frame with no impediments to closing to meet set standards. b Maintenance Supervisor/DON/designee will inspect all doors throughout the facility monthly to ensure there are no penetrations and they have no impediments to closing and latching into the frame as a part of the facility's Preventive	

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	the passage of smoke. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation with the Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., the corridor door to the medicine room in the central wing nurse's station was exposed to the corridor, however when tested, the door would not latch into the frame. The crash plate on the door frame was taped over with duct tape which prevented the latching hardware to operate properly. Based on interview at the time of observation, the Environmental Director confirmed that the door would not latch. The tape was removed at the time of the survey. The finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is** 08/06/2024**.**	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction box in the East Wing was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., resident room 136 contained an electrical junction box which had exposed wiring. Multiple wires were exposed and tied off using wire nuts. Based on interview at the time of observation, the Environmental Director confirmed that wires were exposed in the room and later stated that there could have been a light fixture or call light where the box was when it had been a resident room. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the Environmental Director's office were protected	K 0511	**K511**– It is the intent of the facility to ensure electrical junction boxes in the East Wing are protected and to ensure electrical outlets in the Environmental Director's office are protected according to LSC 19.5.1 and to ensure electrical panel in the East Wing shower room and central nurse's station are secured from non-authorized personnel to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 08/06/2024 the Maintenance Supervisor/designee installed a cover plate to the electrical junction box located in resident room 136 to meet set standards. The Administrator verified the work on 08/06/2024. b On 08/06/2024 the Maintenance Supervisor/designee installed a cover plate to the outlet receptacle located in the Environmental Director's Office to meet set standards. The Administrator verified the work on 08/06/2024. c On 08/06/2024 the	08/22/2024

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	according to LSC 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect approximately 2 staff. Findings include: Based on observation with the Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., in the Environmental Director's office, behind a desk, was an outlet receptacle that did not have a cover plate. Based on interview at the time of observation, the Environmental Director confirmed that the outlet was missing a cover plate and further stated that the outlet has had a missing cover plate for a while and would get the process started to fix it. This finding was reviewed with the Executive Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 electrical panel in the East Wing shower room and central nurse's station were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with		Maintenance Supervisor/designee locked the electrical panel in the East Hall shower room and central Unit's Nurses' station to meet set standards. The Administrator verified the work on 08/06/2024. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 08/06/2024 the Maintenance Supervisor/designee inspected all electrical boxes throughout the facility to ensure the covers were on and to ensure all electrical panels are locked and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 08/06/2024 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical boxes must have properly installed covers and electrical panels are locked to meet set standards. b Maintenance Supervisor/designee will inspect all electrical boxes throughout the facility monthly to ensure the covers are properly installed and ensure the electrical panels are locked as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved	

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	110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with Environmental Director on 08/05/24 between 10:54 a.m. and 12:19 p.m., the electrical panel in the East Hall shower room was unlocked when tested. Furthermore, a breaker panel located at the central unit's nurses' station was also unsecured. That breaker panel included breakers to hall lights and resident rooms lights. Based on interview at the time of observation, the Environmental Director confirmed that the electrical panel was unlocked and further stated that they had a recent power outage which required authorized staff to access the panels and must've not locked the panels. The finding was reviewed with the Executive Director at exit conference. 3.1-19(b)		immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is** 08/06/2024**.**	