	WIEDICAKE & MEDIC			NAME AND ADDRESS OF THE PARTY O	OMB NO. 0938-039	
i i		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
	155251 B. WING		08/05/2024			
NAME OF PROVIDER OR SUPPLIER			2901 W	ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE		
WATERS	S OF HOBART SKIL	LED NURSING FACILITY, THE	HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	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		E 0000			
	Waters of Hobart Si found in compliance Preparedness Requi	Preparedness survey, The killed Nursing Facility was e with Emergency rements for Medicare and ing Providers and Suppliers, 42				
	the survey, the cens					
	Quality Review con	npleted on 08/07/24				
K 0000						
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 0000			
	Survey Date. 00/03	<u>202</u> I				
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	55251				
	At this Life Safety	Code survey, The Waters of				

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

TITLE (X6) DATE

Kristina Herrera Executive Director 08/22/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342		
(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
	Hobart Skilled Nurse compliance with Research Medicare, 42 CFR Strom Fire and the 20 Protection Associate Code, (LSC), Chapter Occupancies and 41 The original one stowest wing and admit basement was deterned to the constructed prior to Type V (111) was a sit was surveyed as constructed with LSC Chapter 1 The facility has a first smoke detectors are installed building is partially powered emergency	sing Facility was found not in quirements for Participation in Subpart 483.90(a), Life Safety 012 edition of the National Fire ion (NFPA) 101, Life Safety er 19, Existing Health Care 0 IAC 16.2. The facility consisting of the inistrative area with a partial mined to be of Type II (222) as fully sprinklered. A later consisting of the east wing March 2003, determined to be lso fully sprinklered, therefore one building in accordance 9. The alarm system with hard wired the corridors and spaces open the protected by a 230 kW diesel of generator. The facility has and had a census of 49 at the			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance,			
	inspection and tes	ting are maintained in a d readily available.			

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Event ID:

6QFK21 Facility ID: 000154

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08/26/2024 PRINTED: FORM APPROVED

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 B. WING 08/05/2024 155251 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2901 W 37TH AVE WATERS OF HOBART SKILLED NURSING FACILITY, THE **HOBART. IN 46342** (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 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 K 0353 K353 - It is the intent of the 08/22/2024 failed to maintain the ceiling construction of 1 of 1 facility to ensure to maintain the maintenance storage room. The ceiling tiles trap ceiling construction of the hot air and gases around the sprinkler and cause maintenance storage room and to the sprinkler to operate at a specified temperature. ensure to maintain the ceiling NFPA 13, 2010 edition, 8.5.4.11 states the distance construction in the bathroom of between the sprinkler deflector and the ceiling resident room 151/153 to meet set above shall be selected based on the type of standards sprinkler and the type of construction. This **1.CORRECTIVE ACTIONS** deficient practice affects approximately 20 TAKEN: residents and staff. 1.On 08/06/2024 the Maintenance Supervisor installed Findings include: the missing ceiling tile in the maintenance storage room to Based on observation during a tour of the facility meet set standards. The with the Environmental Director on 08/05/24 Administrator verified the work on between 10:54 a.m. and 12:19 p.m., in the 08/06/2024. suspended ceiling the maintenance storage room 2.On 08/06/2024 the had a drop ceiling which was missing a tile Maintenance Supervisor repaired exposed the ceiling about approximately one foot. the angular space with a one hour This condition could delay the activation of the fire rated material in the shared sprinklers installed on the suspended ceiling. bathroom for resident rooms 151 Based on interview at the time of the observation. and 153 to meet set standards. the Environmental Director confirmed that the The Administrator verified the work ceiling tile was missing and further stated that she on 08/06/2024. was unaware how long the tile had been missing. 2.ALL OTHERS WITH

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The finding was reviewed with the Executive

Director during the exit conference.

Event ID:

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POTENTIAL TO BE AFFECTED:

and visitors have the potential to be affected but none were.

1.All residents and all staff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
ANI	PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
155251		B. WING 08/05/2024			/2024			
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			
NA	ME OF P	ROVIDER OR SUPPLIEF	₹			/ 37TH AVE		
WA	ATERS	OF HOBART SKIL	LED NURSING FACILITY, THE			RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DLAN OF CORRECTION		(X5)
PRE	EFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
T.	AG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
		3.1-19(b)				3.MEASURES TO PREVEN	Т	
						REOCCURRENCE:		
		2. Based on observa	ation and interview, the facility			1.On 08/06/2024 the		
		failed to maintain th	he ceiling construction in the			Administrator in serviced the		
		bathroom of resider	nt room 151/153. The ceiling			Maintenance Supervisor/desig	jnee	
		traps hot air and gas	ses around the sprinkler and			on the requirement to ensure	all	
		cause the sprinkler	to operate at a specified			ceiling tiles are present and th	ere	
		temperature. NFPA	13, 2010 edition, 8.5.4.1.1			are no annular spaces around	the	
		states the distance b	between the sprinkler deflector			sprinkler heads to meet set		
		_	ve shall be selected based on			standards.		
		the type of sprinkle	r and the type of construction.			2.Maintenance		
		_	ice could affect approximately			Supervisor/designee will ensu	re all	
		3 staff and an unkno	own number of residents.		ceiling tiles are present and there		ere	
					are no annular spaces around the		the	
		Findings include:			sprinkler heads monthly as a part			
				of the facility's Preventive				
			on with the Environmental	Maintenance Program and				
			4 between 10:54 a.m. and 12:19			document those inspection re-		
			of the shared bathroom for			as appropriate. If any issues		
			and 153 had one sprinkler head			discovered, they will be addre		
			space measuring approximately			and resolved immediately. Th		
		-	diameter. Based on interview at	Maintenance Supervisor/designee				
			tion, the Environmental			will review with the Administra	tor	
			lged the annular space and			the inspection results.		
			he will get the process started			3.The Administrator will		
		to fix the issues.				monitor adherence to the		
		Tl C 1'	oissand aniah ah a East ai			Preventative Maintenance		
			viewed with the Executive		schedule and validate the			
		Director at exit con	ference.			Preventative Maintenance		
		2.1.10/1-)				documentation is in place.	n./=	
		3.1-19(b)				4.MONITORING CORRECT	IVE	
						ACTION:		
						1.The inspection results		
						be presented by the Maintena	rice	
						Supervisor/designee to the		
						Administrator monthly and the Administrator will present the		
						inspection results at the month	bly	
						Quality Assurance/Performan	-	
						Improvement (QA/PI) meeting		

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

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SU				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 01 COMPLE					
		155251	B. WING 08/05/2024				
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(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)	i.C	DATE
K 0363 SS=E Bldg. 01	than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible covering is not except to covering with a covering to covering with a covering to covering with a covering covering to covering the cover	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain			Inspection results and system components will be reviewed at the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 08/06/2024	n s	

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Event ID:

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Facility ID: 000154

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	R MEDICARE & MEDIC		•		OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155251	B. WING 08/05/2024				
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			2901 W	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	permitted. Nonratuunlimited height a meeting 19.3.6.3.1 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restricesistance of glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc. 1. Based on observative failed to ensure 1 ocentral wing to the resist the passage of corridor openings in enclosures of vertice hazardous areas resure made of 1 3/4 in other material capal 20 minutes. Doors in compartments are opassage of smoke. Or ooms containing flow materials have posilatches are prohibitor requirements do no do not contain flam Clearance between covering is not exception.	door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments of ctions in area or fire as or frames in window. Parts 403, 418, 460, 482, as details of doors such as angs, automatics closing ation and interview, the facility of 1 medicine room doors for corridor would completely of smoke. Doors protecting an other than required all openings, exits, or its the passage of smoke and and he solid-bonded core wood or ble of resisting fire for at least an fully sprinklered smoke and when solid-bonded core wood or ble of resisting fire for at least an fully sprinklered smoke and when solid-bonded core wood or ble of resisting fire for at least an fully sprinklered smoke and when solid-bonded core wood or ble of resisting fire for at least an fully sprinklered smoke and when solid-bonded core wood or ble of resisting fire for at least an fully sprinklered smoke and should be of resisting the doors to ammable or combustible tive latching hardware. Roller apply to auxiliary spaces that mable or combustible material, bottom of door and floor reading 1 inch. Powered doors 1.9 are permissible if provided all of keeping the door closed of is applied. There is no	K 0363	K363 – It is the intent of the facility to ensure medicine roo doors for central wing to the corridor would completely resi the passage of smoke and to ensure medicine room corrido door on the central wing are provided with a means suitabl keeping the door closed, have impediment to closing, latchin and would resist the page of smoke to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 08/06/2024 the Maintenance Supervisor/design sealed the penetration on the to the central nurse's station medicine room with a one hourated material to meet set standards. The Administrator verified the repairs on 08/06/20	gnee door ur fire		

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Event ID:

6QFK21

Facility ID: 000154

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(Y2) DATE CLIBVEY		
		X1) PROVIDER/SUPPLIER/CLIA	` '			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>01</u>			COMPLETED	
		155251	B. W	B. WING 08/05/20			² 024
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
<u>-</u>					37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	impediment for the	closing of the doors. Hold					
	open devices that re	elease when the door is			b On 08/06/2024 the		
	pushed or pulled are	e permitted. Nonrated			Maintenance Supervisor/desig	gnee	
	protective plates of	f unlimited height are			removed the tape from the cra	ash	
	permitted. Dutch do	oors meeting 19.3.6.3.6 are			plate on the door to the medic	ine	
	permitted. Door fra	mes shall be labeled and made			room in the central wing nurse	e's	
	of steel or other ma	terials in compliance with 8.3,			station to ensure the door clos	ses	
	unless the smoke co	ompartment is sprinklered.			and latches into the frame to r	neet	
	Fixed fire window	assemblies are allowed per 8.3.			set standards. The Administra	ator	
	In sprinklered comp	partments there are no			verified the repairs on		
	restrictions in area	or fire resistance of glass or			08/06/2024.		
	flames in window a	ssemblies. This deficient			2 ALL OTHERS WITH		
	practice could affec	et approximately 5 staff and an		POTENTIAL TO BE AFFECTED:			
	unknown number o	f residents.	a All residents and all staff and				
			visitors have the potential to be				
	Findings include:		affected but none were. The				
	_				Maintenance Supervisor/desig	nee	
	Based on observation	on on 08/05/24 between 10:54			inspected all doors and found	-	
	a.m. and 12:19 p.m.	. during a tour of the facility			other negative findings.		
		ental Director, the door to the			3 MEASURES TO PREVE	NT	
		on medicine room had an			REOCCURRENCE:		
	approximate one-qu	arter inch circular shaped hole			a On 08/06/2024 the		
		dle to the door that opened to			Administrator in serviced the		
		on interview at the time of	Maintenance Supervisor/Nursir			ina	
		vironmental Director			Staff/Don on the requirement	-	
	· · · · · · · · · · · · · · · · · · ·	door had a penetration and			provide corridor doors that wo		
		essed before the end of the			resist the passage of smoke w		
	_	n was sealed by the end of the			no penetrations and doors tha		
	survey.	•			would close completely and la		
					into the frame with no		
	The finding was rev	viewed with the Environmental			impediments to closing to mee	et	
	Director at exit con				set standards.		
					b Maintenance		
	3.1-19(b)				Supervisor/DON/designee will		
	, ,				inspect all doors throughout th		
	2. Based on observa	ation and interview, the facility			facility monthly to ensure there		
		f 1 medicine room corridor door			no penetrations and they have		
		were provided with a means			impediments to closing and		
	_	g the door closed, had no			latching into the frame as a pa	art of	
		ing, latching and would resist			the facility's Preventive		
		- ~					

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

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-039

ľ		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUILDING B. WING	01	COMPLETED 08/05/2024
		133231	<u> </u>		00/03/2024
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>		ADDRESS, CITY, STATE, ZIP COD	
WATERS	S OF HOBART SKIL	LED NURSING FACILITY, THE		V 37TH AVE RT, IN 46342	
				1	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		te. This deficient practice	TAG	Maintenance Program and	DATE
		imately 5 staff and an unknown		document those inspection re-	sults
	number of residents			as appropriate. If any issues	
				discovered, they will be addre	
	Findings include:			and resolved immediately. Th	
				Maintenance Supervisor/desig	
	Based on observation	on with the Environmental		will review with the Administra	
	Director on 08/05/2	4 between 10:54 a.m. and 12:19		the inspection results.	
	p.m., the corridor do	oor to the medicine room in the		c The Administrator will	
	central wing nurse's	station was exposed to the		monitor adherence to the	
		when tested, the door would		Preventative Maintenance	
		ame. The crash plate on the			
	_	ed over with duct tape which			
	-	ng hardware to operate		documentation is in place.	
		interview at the time of		4 MONITORING	
		vironmental Director		CORRECTIVE ACTION:	
		loor would not latch. The tape		a The inspection results wi	
	was removed at the	time of the survey.		presented by the Maintenance	;
	Tl C 1:	i did- dh - Edi		Supervisor/designee to the	
	Director during the	viewed with the Executive		Administrator monthly and the	•
	Director during the	exit conference.		Administrator will present the inspection results at the montl	nlv.
	3.1-19(b)			Quality Assurance/Performan	-
	3.1-17(0)			Improvement (QA/PI) meeting	
				Inspection results and system	•
				components will be reviewed	
				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	
				08/06/2024.	
i l			I	1	l

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QFK21

Facility ID: 000154

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/05/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE		2901 \	ADDRESS, CITY, STATE, ZIP COD W 37TH AVE RT, IN 46342		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using gomplies with NFF Code, electrical words are resident of the service provided round as the service provided round service p	Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 1, 9.1.2 1, 9.1.2 1, 9.1.3 Heition box in the 1, 1, 1, 1, 1, 1, 2, 2, 3, 3, 4, 3, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4,	K 0511	K511– It is the intent of the facto ensure electrical junction be in the East Wing are protected and to ensure electrical outled the Environmental Director's care protected according to LS 19.5.1 and to ensure electrical panel in the East Wing showeroom and central nurse's staticare secured from non-authorization personnel to meet set standar CORRECTIVE ACTIONS TAKEN: a On 08/06/2024 the Maintenance Supervisor/designistalled a cover plate to the electrical junction box located resident room 136 to meet set standards. The Administrator verified the work on 08/06/2024. b On 08/06/2024 the Maintenance Supervisor/designistalled a cover plate to the creceptacle located in the Environmental Director's Officimeet set standards. The Administrator verified the work 08/06/2024.	cility 08/22/2024 oxes of test in office C I r oon ozed ods. Signee in the contract of the contract oxer oxer oxer oxer oxer oxer oxer oxer

Environmental Director's office were protected

On 08/06/2024 the

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155251	B. WING 08/05/2024			/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ 37TH AVE		
WATER!	S OF HOBART SKII	LLED NURSING FACILITY, THE			RT, IN 46342		
	T		_		T		Т
(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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	_	9.5.1. NFPA 70, 2011 Edition,			Maintenance Supervisor/design		
		ptacle Faceplates (Cover			locked the electrical panel in t		
		ceptacle faceplates shall be			East Hall shower room and ce		
		ompletely cover the opening			Unit's Nurses' station to meet		
	_	mounting surface. This			standards. The Administrator		
	-	ould affect approximately 2			verified the work on		
	staff.				08/06/2024.		
	F' 1' ' 1 1				2 ALL OTHERS WITH		
	Findings include:				POTENTIAL TO BE AFFECT		
	D 1 1	and the state of			a All residents and all staff		
		on with the Environmental			visitors have the potential to b	e	
		24 between 10:54 a.m. and 12:19			affected but none were. On		
	_	nmental Director's office, behind			08/06/2024 the Maintenance		
		et receptacle that did not have			Supervisor/designee inspecte		
	_	d on interview at the time of			electrical boxes throughout the		
		vironmental Director			facility to ensure the covers w	ere	
		outlet was missing a cover		on and to ensure all electrical			
	_	ated that the outlet has had a			panels are locked and found r	10	
		for a while and would get the			other negative findings.		
	process started to fi	IX 1t.			3 MEASURES TO PREVE	NT	
	Tr. C 1.	i i ala p			REOCCURRENCE:		
	Director at exit con	viewed with the Executive			a On 08/06/2024 the		
	Director at exit con	ierence.			Administrator inserviced the		
	2.1.10(b)				Maintenance Supervisor/design		
	3.1-19(b)				on the requirement that electr		
	2 Rosed on observe	otion and interview the facility			boxes must have properly ins		
		ation and interview, the facility f 2 electrical panel in the East			covers and electrical panels a	ie	
		and central nurse's station			locked to meet set standards.		
	_	non-authorized personnel.			b Maintenance Supervisor/designee will inspe	oct	
		tion states 230.62 Energized					
		ipment shall be enclosed as			all electrical boxes throughout	une	
		(A) or guarded as specified in			facility monthly to ensure the	n d	
	230.62(B).	(A) of guarded as specified in			covers are properly installed a		
	1 1	gized parts shall be enclosed			ensure the electrical panels a locked as a part of the facility'		
	* /	t be exposed to accidental					
		guarded as in 230.62(B).			Preventive Maintenance Prog		
		gized parts that are not enclosed			and document those inspection		
	` '	•			results as appropriate. If any		
		n a switchboard, panelboard, or			issues are discovered, they w	ш ре	
	i control board and g	uarded in accordance with	1		addressed and resolved		1

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

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>01</u>			COMPLETED	
155251			B. WING 08/05/2024			/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2901 W 37TH AVE HOBART, IN 46342				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAU		. Where energized parts are		TAG	immediately. The Maintenand		DATE
		ed in 110.27(A)(1) and (A)(2), a			Supervisor/designee will revie		
		or sealing doors providing			with the Administrator the	vv	
	_	l parts shall be provided. This			inspection results.		
	_	could affect approximately 10			c The Administrator will		
	residents and staff.				monitor adherence to the		
					Preventative Maintenance		
	Findings include:				schedule and validate the		
					Preventative Maintenance		
	Based on observati	ion with Environmental		documentation is in place.			
	Director on 08/05/2	24 between 10:54 a.m. and 12:19		4 MONITORING			
	p.m., the electrical	panel in the East Hall shower	CORRECTIVE ACTION:				
	room was unlocked	d when tested. Furthermore, a	a The inspection results will be				
	breaker panel locat	ted at the central unit's nurses'	presented by the Maintenance				
	station was also un	secured. That breaker panel			Supervisor/designee to the		
	included breakers t	to hall lights and resident rooms			Administrator monthly and the		
	lights. Based on in	terview at the time of			Administrator will present the		
	observation, the Er	nvironmental Director			inspection results at the month	nly	
		electrical panel was unlocked			Quality Assurance/Performand	ce	
		hat they had a recent power			Improvement (QA/PI) meeting		
		ired authorized staff to access			Inspection results and system		
	the panels and mus	st've not locked the panels.			components will be reviewed I	ру	
					the QA/PI Committee with		
	_	viewed with the Executive			subsequent plans of correction		
	Director at exit cor	nference.			developed and implemented a	ıs	
					deemed necessary to ensure		
	3.1-19(b)				compliance is maintained.		
					This plan of correction		
					constitutes our credible	_	
					allegation of compliance with	n	
					all regulatory requirements.		
					Our date of compliance is		
					08/06/2024.		

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