STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155006	A. BUILDING -- B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY EAST THE	1900 N ALBER ST WABASH, IN 46992

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/29/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/22/24 Facility Number: 000006 Provider Number: 155006 AIM Number: 100290220 At this PSR survey, The Waters of Wabash Skilled Nursing Facility East was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 84 certified beds. At the time of the survey, the census was 53. Quality Review completed on 10/23/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/29/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 10/22/24 Facility Number: 000006 Provider Number: 155006 AIM Number: 100290220	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Logan Vance	Administrator	11/04/2024

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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	At this PSR survey, The Waters of Wabash Skilled Nursing Facility East was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms with exception of rooms 214 and 115 contained battery operated smoke alarms. The facility has a capacity of 84 and had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered with the exception of two detached garages used for storage of maintenance equipment and parts, a detached shed used for storage of repair parts and another detached shed used for the storage of activity supplies. Quality Review completed on 10/23/24			
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observations, records review, and interviews, the facility failed to ensure 1 of 3 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building	K 0372	K372– It is the intent of the facility to ensure smoke barrier walls are constructed to requirements according to the authority having jurisdiction (AHJ) to meet set standards.	10/23/2024

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	assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice affects all residents in the facility. Findings include: Based on observation with the Administrator on 10/22/24 at 1:30 p.m., around pipes above the ceiling tiles of the100-hall smoke barrier wall, penetrations were sealed with joint compound or plaster. Based on records review at 1:35 p.m., there was no documentation to show the compound meets ASTM 814. Based on interview at the time of observation, the Administrator stated the 200-smoke wall was repaired with the proper caulk, but the 100-smoke wall was missed and still contained joint compound to seal penetrations. This finding was reviewed with the Administrator during the exit conference. This deficiency was cited on 08/28/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		1. CORRECTIVE ACTIONS TAKEN: a. On _____10/23/24_____ the Maintenance Supervisor/designee sealed the penetrations around pipes above the ceiling tiles of the 100 smoke barrier wall with a one hour fire rated material to meet set standards ASTM E 814. The Administrator verified the work on ___10/23/24____ . 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. On ____10/23/24____ the Maintenance Supervisor/designee inspected all smoke barrier walls and ceilings throughout the facility for penetrations and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On _____10/23/24____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement that smoke barriers walls and ceilings are constructed to provide at least a one-hour resistance rating and meet ASTM E 814 and must be free from penetrations to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls and ceilings throughout the facility monthly to ensure they remain free of penetrations as a part of	

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			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. 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. Monitoring will be documented with the Fire Wall Penetration QA/PI Tool by the Maintenance Supervisor/designee. 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	

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			compliance is ____10/23/24_____.	