STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING -- B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/23 Facility Number: 000578 Provider Number: 155627 AIM Number: 100267810 At this Emergency Preparedness survey, The Waters of Wabash Skilled Nursing Facility West was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 44 and had a census of 19 at the time of this survey. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 09/05/23	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required			

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	full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is	E 0039	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Administrator and the Maintenance Supervisor/designee conducted a community or facility-based annual exercise and completed documentation for the exercise to meet set standards. 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. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that a community or facility-based	09/18/2023

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	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Tech (MT) on 08/29/23 at 12:15 p.m., no documentation of a community or facility based annual exercise was available for review, however, documentation of one annual exercise on 05/26/23 was available for review. Based on interview at the time of record review, the MT stated the facility did not participate in a full-scale exercise that is community-based but completed one facility based exercise within the last 12 months. There was no documentation provided for a second exercise. This finding was reviewed with the Administrator and MT at the exit conference.		exercise must be conducted annually and documentation retained to meet set standards. b. Maintenance Supervisor/designee will work with the Administrator to ensure a community or facility-based exercise is conducted and documented to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/18/2023.	
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: 08/29/2023 Facility Number: 000578 Provider Number: 155627 AIM Number: 100267810 At this Life Safety Code survey, The Waters of Wabash Skilled Nursing Facility West 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 battery powered smoke detection in the resident sleeping rooms, Activities room, Conference room, and Therapy room. The facility has a capacity of 44 and had a census of 19 at the time of this survey.	K 0000		

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/05/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting 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 and interview, the facility failed to ensure 4 of 4 battery backup emergency lights were tested monthly for 30 seconds and annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Tech (MT) on 08/29/23 at 11:30 a.m., annual testing for the battery backup emergency lights was unavailable. The Battery Operated Emergency Light Test Log indicated the last annual 90 minute testing for the 4 battery backup emergency lights was conducted on 01/22. The monthly maintenance log for the 30 second test for the battery backup emergency light was	K 0291	**1.CORRECTIVE ACTIONS TAKEN**: 1.On 09/15/2023 the Maintenance Supervisor/designee conducted the monthly and annual testing for the battery backup emergency lights and documented the results on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. The Administrator verified the work on 09/15/2023 . **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. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to provide and maintain emergency lighting and conduct the monthly and annual testing and document the results	09/18/2023

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	155627	A. BUILDING 01 B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 ALBER ST WABASH, IN 46992

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	missing for August through December of 2022 and July 2023. Based on an interview at the time of records review, the MT stated the missing monthly 30 second tests identified and annual 90 minute testing for the six battery backup emergency lights has not been conducted. These findings were reviewed with the Administrator and MT at the exit conference. 3.1-19(b)		to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain emergency lighting and conduct the monthly and annual testing as a part of the facility's Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. 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. 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	

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WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 ALBER ST WABASH, IN 46992

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/18/2023.**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 2 exits in the kitchen in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 5 kitchen staff. Findings include: Based on observation with the Maintenance Tech (MT) on 08/29/23 at 2:10 p.m., the exit door leading outside from the kitchen storage room was not obvious as an exit and had no exit sign. The main	K 0293	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Maintenance Supervisor/designee installed a sign that states Not an Exit at the exit door leading outside from the kitchen storage room to meet set standards. The Administrator verified the work on 09/15/2023 . 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. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee	09/18/2023

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	outside exit door in the kitchen is obvious but the storage room exit door window was painted which would not allow anyone to see that it is an outside exit. Based on interview at the time of observation, the MT acknowledged the aforementioned condition and confirmed that the path of egress was not obvious. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)		on the requirement to ensure to provide and maintain exit and directional exit signs to mark exit paths to reach the exits and in serviced him on exits that are not considered to be emergency exits to meet set standards. b. Maintenance Supervisor/designee will conduct a monthly check of all emergency exit signs and non-exiting doors and document those inspection results on the Emergency Lights & Signs Test Log as a part of the facility's Preventive Maintenance Program. 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	

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			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 09/18/2023.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in 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)			

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	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 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Maintenance Tech (MT) on 08/29/23 at 1:50 p.m., storage room #21 contained over 20 boxes of supplies, 5 totes, and furniture, and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the MT agreed the storage room contained a large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room did not self-close and latch when tested. The finding was reviewed with the Administrator and the MT during the exit conference. 3.1-19(b)	K 0321	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Maintenance Supervisor/designee installed a self-closing device to ensure door self closes and latches into the frame on storage room #21 to meet set standards. The Administrator verified the work on 09/15/2023 . **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 09/15/2023 the Maintenance Supervisor/designee inspected all hazardous area doors for self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee/all staff on the requirement that all hazardous area doors must be protected with a self-closing device and self closes and latches into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors	09/18/2023

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			throughout the facility monthly to ensure there is a self-closing device and the door self closes and latches into the frame 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. 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.**	

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			Our date of compliance is 09/18/2023.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 12 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.	K 0355	**1.CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the facilities Maintenance Supervisor/designee performed the monthly inspection on the two fire extinguishers located by room 11 and one located in the dining room and documented the inspection to meet set standards. The Administrator verified the work on 09/15/2023 . **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee that portable fire extinguishers must be inspected monthly and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure portable fire extinguishers are	09/18/2023

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	Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect up to 15 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Tech (MT) on 08/29/23 at 2:05 p.m. and 2:20 p.m., the monthly inspection tag on two fire extinguishers, one located by room 11 and one located in the Dining room, lacked documentation of a monthly inspection for July 2023. Based on interview at the time of observation, the MT confirmed the fire extinguisher located by room 11 and in the Dining room were missing the July 2023 monthly visual inspection. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)		inspected monthly and documented as a part of the facility's monthly 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. **3.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. 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 09/18/2023.**	

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K 0363 SS=D 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 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			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 25 corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 12. Findings include: Based on observation with the Maintenance Tech (MT) on 08/29/23 at 1:55 p.m., the corridor door to resident sleeping room 12 would not close into the frame when tested. Based on interview at the time of observation, the MT agreed the corridor door to room 12 would not close into the door frame because the bed was an impediment to closing. The finding was reviewed with the Administrator and MT during the exit conference. 3.1-19(b)	K 0363	**1. CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Maintenance Supervisor/designee relocated the bed so the door would fully close and latch into the frame in resident sleeping room 12 to meet set standards. The Administrator verified the work on 09/15/2023 . **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 corridor doors to ensure they latch fully into the frame and for positive latching hardware and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors must latch fully into the frame including to ensure beds are not obstructing the door to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they latch fully into the frame including to ensure beds are not obstructing	09/18/2023

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			the door 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. 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 09/18/2023.**	

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K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff and 10 residents in the vicinity of the two mechanical rooms. Findings include: Based on observation during a tour of the facility with the Maintenance Tech (MT) on 08/29/23 at 2:10 p.m. the two fuel fired water heaters in the mechanical room did not have current inspection certificates, one of the fuel fired water heaters had an inspection certificate with an expiration date of 08-22-23. Based on interview at the time of the observation, the MT agreed the fuel fired water heater inspection certificates were expired or unavailable. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)	K 0500	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/14/2023 a Certified Water Heater Inspector was contacted to inspect the two fuel fired water heaters in the mechanical room and provided the facility with Certificates of Inspection to meet set standards. The Administrator will verify the inspections and receipt of the documentation upon completion. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that fuel-fired water heaters must be inspected and a Certificate of Inspection retained at the facility to meet set standards. b. Maintenance Supervisor/designee will check all	09/18/2023

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	155627	A. BUILDING 01 B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 ALBER ST WABASH, IN 46992

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			fuel-fired water heaters annually to ensure they are inspected and documentation retained at the facility 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. 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.**	

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			Our date of compliance is 09/18/2023	
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 Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring's in the attic 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 10 residents in the South hall. Findings include: Based on observation during a tour of the facility with the Maintenance Tech (MT) on 08/29/23 at 2:25 p.m., in the south end of the attic there was a 4 inch by 4 inch junction box with exposed wires because there was no cover attached. Based on interview at the time of observation, the MT acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)	K 0511	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Maintenance Supervisor/designee installed a cover on the junction box that had exposed wires in the south end of the attic to meet set standards. The Administrator verified the repairs on 09/15/2023. 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 09/15/2023 the Maintenance Supervisor/designee inspected all electrical outlets and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that electrical outlets must be installed with a cover plate to meet set standards. b. Maintenance	09/18/2023

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			Supervisor/designee will inspect all outlet boxes monthly to ensure they have a cover plate 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 09/18/2023.**	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Tech (MT) on 08/29/23 at 10:30 a.m., the fourth quarter first shift fire drill report was missing documentation of a completed fire drill. There were 2 second shift fire drills done in the fourth quarter. Based on interview at the time of record review, the MT stated the drill was completed but not at the correct time. This finding was reviewed with the Administrator and MT at the exit conference. 3.1-19(b)	K 0712	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b. On 09/15/2023 the Maintenance Supervisor/designee conducted a fire drill for each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the drills on 09/15/2023. 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. 3. **MEASURES TO PREVENT**	09/18/2023

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	3.1.51(c)		**REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and that documentation be retained in the facility's Life Safety Binder 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. b. 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	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/18/2023.**	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strip in the Therapy room meets UL 1363. This deficient practice could affect up to 2 residents.	K 0920	1. **CORRECTIVE ACTIONS TAKEN**: a. On 09/15/2023 the Maintenance Supervisor/designee	09/18/2023

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	Findings include: Based on observation with the Maintenance Tech (MT) on 08/29/23 at 1:55 p.m., in the Therapy room there was a power strip in use that did not meet UL-1363. Based on interview at the time of observation, the MT agreed a power strip was in use in the Therapy room and did not meet UL-1363. This finding was reviewed with the Administrator and MT during the exit conference. 3.1-19(b)		removed the power strip from the Therapy Room to meet set standards. The Administrator verified the removal of the cord on 09/15/2023. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 09/15/2023 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designee and all other staff including the Physical Therapy Department on the requirement that power strips are not to be used in the facility to meet set standards. b. Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly and remove any power strips found 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. c. The Administrator will	

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			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 insure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/18/2023.**	