STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 08/29/2023			ETED		
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			1720 AL	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0000	REGULATORTO	R LSC IDENTIFTING INFORMATION		IAU			DATE
Bldg		paredness Survey was ndiana Department of Health in 2 CFR 483.73.	E 00	000			
	Survey Date: 08/2	9/23					
	Facility Number: 0 Provider Number: AIM Number: 100	155627					
	Waters of Wabash was found not in co Preparedness Requ Medicaid Participa CFR 483.73. The shad a census of 19	Preparedness survey, The Skilled Nursing Facility West ompliance with Emergency irements for Medicare and ting Providers and Suppliers, 42 facility has a capacity of 44 and at the time of this survey. 42 CFR, Subpart 483.73 is NOT					
	MET as evidenced Quality Review con	by: mpleted on 09/05/23					
E 0039 SS=F Bldg	441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § §485.625(d)(2), § (2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
	-	ons" under §485.727,					

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

TITLE (X6) DATE

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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST				1720 AL	ADDRESS, CITY, STATE, ZIP COD BER ST SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	_	020, RHCs/FQHCs at RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct he emergency plan cility] must do all of the					
	community-based (A) When a commot accessible, confunctional exercise (B) If the [facinatural or man-material or man-material or man-material exempt from en community-based	full-scale exercise that is a levery 2 years; or munity-based exercise is onduct a facility-based e every 2 years; or mulity experiences an actual eade emergency that requires emergency plan, the [facility] or individual, facility-based e following the onset of the					
	actual event. (ii) Conduct an ad every 2 years, oppor functional exercity of this section include, but is not (A) A second full-section.	Iditional exercise at least posite the year the full-scale cise under paragraph (d)(2) s conducted, that may limited to the following: scale exercise that is I or individual, facility-based e; or					
	led by a facilitator discussion using a clinically-relevant set of problem sta messages, or pre to challenge an er (iii) Analyze the [famaintain documer exercises, and err	emergency scenario, and a stements, directed pared questions designed					

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Event ID:

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF 1	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD LBER ST			
WATERS	S OF WABASH SKII	LLED NURSING FACILITY WEST	Γ		SH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	the patient's home conduct exercises plan at least annu the following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emerg of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exiled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepto challenge an er (3) Testing for hospice (1) Participate (1) Participate (1) Participate (2) Participate (3) Testing for hospic (1) Participate (1) Pa	spices that provide care in a. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or a munity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise following the gency event. In additional exercise every 2 eyear the full-scale or experienced, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed						

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exercises to test the emergency plan twice per year. The hospice must do the following:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			1720 AL	DDRESS, CITY, STATE, ZIP COD BER ST SH, IN 46992			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, conduct facility-based functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extenditator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency is emergency scena statements. *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [for conduct exercises exercis	nunity-based exercise is not lect an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem led messages, or prepared ed to challenge an espice's response to and natation of all drills, tabletop nergency events and revise ergency plan, as needed.					
	CAH] must do the (i) Participate in a that is community	an annual full-scale exercise					

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Event ID:

 $7YMD21 \qquad {\tt Facility\ ID:} \quad 000578$

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL			COMPLETED		
		155627	B. WING	·		08/29/2023		
NAME OF F	PROVIDER OR SUPPLIER	-		STREET A	DDRESS, CITY, STATE, ZIP COD	_		
					BER ST			
WATERS	OF WABASH SKII	LLED NURSING FACILITY WES	T \	WABAS	5H, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1 ' '	nunity-based exercise is not						
		ct an annual individual,						
	1	ctional exercise; or						
		Hospital, CAH] experiences						
		or man-made emergency						
		ation of the emergency						
		is exempt from engaging in ull-scale community based						
	l '	ty-based functional exercise et of the emergency event.						
	T	an [additional] annual						
	· '	at may include, but is not						
	limited to the follow	-						
		scale exercise that is						
	community-based							
	1	ctional exercise; or						
	1	ock disaster drill; or						
	, ,	exercise or workshop that						
		or and includes a group						
	discussion, using	— ·						
	_	emergency scenario, and a						
	set of problem sta							
	1	pared questions designed						
	to challenge an er	·						
	_	he [facility's] response to						
	1 ' '	umentation of all drills,						
		s, and emergency events						
	•	cility's] emergency plan, as						
	needed.							
	*[Eor DACE at \$46	30 84/d\·1						
	*[For PACE at §46	· · -						
	1 ' '	ACE organization must						
	plan at least annu	to test the emergency						
	organization must	-						
	1 -	an annual full-scale exercise						
	that is community							
	1	nunity-based exercise is not						
	1 ' '	ict an annual individual,						
	facility-based fund							

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155627	B. W	ING		08/29/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			BER ST		
WATERS	S OF WARASH SKII	LLED NURSING FACILITY WEST			SH, IN 46992		
		ELEB NOROMO PROJETT WEST		W LB/ LC	11, 11 10002		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
	` '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	-	gaging in its next required					
		nity based or individual,					
		ctional exercise following the					
	onset of the emer						
	, ,	n additional exercise every					
		the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited to	_					
	, ,	scale exercise that is or individual, a facility					
	based functional	•					
	(B) A mock disas						
	, ,	ercise or workshop that is					
		and includes a group					
	discussion, using	- ·					
	_	emergency scenario, and a					
	set of problem sta	- ·					
	-	pared questions designed					
	to challenge an er	•					
	_	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	`	,					
	*[For LTC Facilitie	es at §483.73(d):]					
	_	ity] must conduct exercises					
		ency plan at least twice per					
		announced staff drills using					
	the emergency pro	ocedures. The [LTC facility,					
	ICF/IID] must do t	he following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund	ctional exercise.					
	(B) If the [LTC fac	ility] facility experiences an					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLETED	
		155627	B. W	ING		08/29/	/2023
NAME OF F	DROWINED OF GIRDI ICI		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		1720 AL	_BER ST		
	OF WABASH SKI	LLED NURSING FACILITY WEST		WABAS	SH, IN 46992		
(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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		nan-made emergency that					
	•	of the emergency plan, the					
	1	mpt from engaging its next					
		lle community-based or					
	-	based functional exercise					
	_	et of the emergency event.					
	' '	dditional annual exercise					
	following:	but is not limited to the					
	_	scale exercise that is					
	' '	or an individual, facility					
	based functional						
	(B) A mock disas						
	, ,	ercise or workshop that is					
	led by a facilitator						
	discussion, using	- ·					
	_	emergency scenario, and a					
	set of problem sta	-					
		pared questions designed					
	to challenge an er	• •					
	(iii) Analyze the [l	LTC facility] facility's					
	response to and n	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	· · · · -					
		CF/IID must conduct					
	exercises to test t	he emergency plan at least					
		e ICF/IID must do the					
	following:						
		n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ıct an annual individual,					
		ctional exercise; or.					
		experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
	is exempt from en	gaging in its next required					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 08/29/2023	
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY WES	1720	r address, city, state, zip co ALBER ST ASH, IN 46992	DD .	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION
TAG			TAG	DEFICIENCY)		DATE
	full-scale commun	nity-based or individual,				
	facility-based fund	tional exercise following the				
	onset of the emer	-				
	` '	ditional annual exercise				
	<u>-</u>	but is not limited to the				
	following:					
		scale exercise that is				
	community-based					
	(B) A mock disast	tional exercise; or				
	, ,	er drill, or ercise or workshop that is				
	, ,	and includes a group				
	discussion, using	_ ,				
	_	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	-	CF/IID's response to and				
		ntation of all drills, tabletop				
		nergency events, and revise				
		rgency plan, as needed.				
	*[For HHAs at §48					
		e HHA must conduct				
		he emergency plan at				
		e HHA must do the				
	following:	full apple everging that is				
		full-scale exercise that is				
	community-based	; or ommunity-based exercise				
	, ,	conduct an annual				
		based functional exercise				
	every 2 years; or.	Sacca fariotional Caciolec				
		A experiences an actual				
	` '	ade emergency that requires				
		mergency plan, the HHA is				
		iging in its next required				
		nity-based or individual,				
		tional exercise following the				
	onset of the emer					

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	l í	UILDING	NSTRUCTION	COMP	E SURVEY PLETED 9/2023
	PROVIDER OR SUPPLIEI	R LLED NURSING FACILITY WES	Γ	1720 AL	ADDRESS, CITY, STATE, ZIP COD BER ST SH, IN 46992	•	_
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(ii) Conduct an ad	lditional exercise every 2					
	years, opposite th	ne year the full-scale or					
	functional exercis	e under paragraph (d)(2)(i)					
	of this section is o	· · · · · · · · · · · · · · · · · · ·					
		limited to the following:					
		full-scale exercise that is					
	community-based						
	1	ctional exercise; or					
	, ,	isaster drill; or					
	` '	p exercise or workshop that					
	discussion, using	tor and includes a group					
	_	emergency scenario, and a					
	I	atements, directed					
	1	pared questions designed					
	to challenge an e	·					
	_	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §4	-					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	_					
		er-based, tabletop exercise					
	<u> </u>	ast annually. A tabletop					
	1	a facilitator and includes a					
		using a narrated, clinically					
	_	cy scenario, and a set of nts, directed messages, or					
	I -	ns designed to challenge an					
	1	If the OPO experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
	1	om engaging in its next					
		xercise following the onset					
	of the emergency	_					
		PO's response to and					
	. ,	ntation of all tabletop					

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Event ID:

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155627 B. WING 08/	MPLETED /29/2023
STREET ADDRESS, CITY, STATE, ZIP COD	/29/2023
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST 1720 ALBER ST WABASH, IN 46992	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDED'S DLAN OF CORRECTION	(X5)
PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
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 plan at least twice per year, including unannounced staff drills using 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	09/18/2023
include, but is not limited to the following: a. A second full-scale exercise that is on the requirement that a	

	MENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2023	
	OF PROVIDER OR SUPPLIE ERS OF WABASH SKI	LLED NURSING FACILITY WES	1720	t address, city, state, zip coe ALBER ST ASH, IN 46992	·	
(X4) II PREFI TAG	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) JLD BE ROPRIATE COMPLETION DATE	
	community-based of functional exercises b. A mock disaster c. A tabletop exerc facilitator that inche a narrated, clinicall and a set of problet messages, or prepare challenge an emerge (iii) Analyze the L' maintain document exercises, and eme LTC facility's emergaccordance with 42 deficient practice of Findings include: Based on record re Maintenance Tech no documentation of based annual exercises and emerged in the second exercise that is conformed in the second exercise that is c	drill; or ise or workshop that is led by a ides a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to gency plan. The facility's response to and ation of all drills, tabletop regency events, and revise the regency plan, as needed in the CFR 483.73(d)(2). This could affect all occupants. Wiew and interview with the (MT) on 08/29/23 at 12:15 p.m., of a community or facility ise was available for review, tation of one annual exercise railable for review, the MT id not participate in a full-scale inmunity-based but completed exercise within the last 12 is no documentation provided ise.		exercise must be conduct annually and documental retained to meet set stands. Maintenance Supervisor/designee will the Administrator to ensure community or facility-base exercise is conducted and documented to meet set standards. If any issues discovered, they will be a and resolved immediately c. The Administrator monitor adherence to the Emergency Preparedness Manual and validate the documentation is in placed. MONITORING CORRECTIVE ACTION: a. At least annually to compliance, the Administ Maintenance Supervisors will review the Emergency Preparedness Policy Maconduct required exercist make changes as necessmeet set standards. The reviews will be documentally appropriate. The Administ present the training result Quality Assurance/ Performs (QA/PI) mere Results and system com will be reviewed by the Committee with subsequental of correction developed a simplemented as deemed necessary to ensure comist maintained. This plan of correction	cited tion idards. work with are a sed id sed did sere addressed y. will elses Policy e. Densure trator and designee cy nual and es and sary to ose ted as strator will dis at the ormance eleting. ponents DA/PI eent plans and	

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

IDENTIFICATION NUMBER 155627	A. BUILDING B. WING		COMPLETED 08/29/2023	
LED NURSING FACILITY WEST	1720 Al	LBER ST		
TATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
		constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/18/2023.	1	
Recertification and State as conducted by the Indiana th in accordance with 42 CFR 2023 0578 55627 57810 ode survey, The Waters of sing Facility West was found th Requirements for icare/Medicaid, 42 CFR ife Safety from Fire and the lational Fire Protection 101, Life Safety Code (LSC), Health Care Occupancies and y was determined to be of action and was fully ility has a fire alarm system in the corridors, areas open pattery powered smoke ent sleeping rooms, aference room, and Therapy as a capacity of 44 and had a me of this survey.	K 0000			
	DENTIFICATION NUMBER 155627 LED NURSING FACILITY WEST TATEMENT OF DEFICIENCIE TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Recertification and State as conducted by the Indiana th in accordance with 42 CFR 2023 0578 55627 57810 ode survey, The Waters of sing Facility West was found th Requirements for icare/Medicaid, 42 CFR ife Safety from Fire and the lational Fire Protection 101, Life Safety Code (LSC), Health Care Occupancies and y was determined to be of action and was fully illity has a fire alarm system in the corridors, areas open battery powered smoke ent sleeping rooms, ference room, and Therapy as a capacity of 44 and had a	Recertification and State s conducted by the Indiana h in accordance with 42 CFR 2023 0578 15627 17810 2024 2025 10578 10627 107 108 109 109 109 109 109 109 109	DENTIFICATION NUMBER 155627 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992 FATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Recertification and State Is conducted by the Indiana In in accordance with 42 CFR 2023 0578 55627 77810 ode survey, The Waters of sing Facility West was found th Requirements for care/Medicaid, 42 CFR ife Safety from Fire and the lational Fire Protection 101, Life Safety Code (LSC), Health Care Occupancies and y was determined to be of action and was fully lithy has a fire alarm system in the corridors, areas open battery powered smoke ent sleeping rooms, ference room, and Therapy as a capacity of 44 and had a	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155627	1	A. BUILDING 01 COMPLETED B. WING 08/29/2023			
NAME OF P	ROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD LBER ST		
WATERS	OF WABASH SKI	LLED NURSING FACILITY WEST	•		SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		residents have customary					
	access were sprinklered. All areas providing						
	facility services were sprinklered.						
	Quality Review completed on 09/05/23						
K 0291	NFPA 101						
SS=F	Emergency Lighting						
Bldg. 01	Emergency Lightin	-					
Ŭ	Emergency lighting of at least 1-1/2-hour						
	duration is provided automatically in						
	accordance with 7	7.9.					
	18.2.9.1, 19.2.9.1						
		eview and interview, the facility	K 0	291	1.CORRECTIVE ACTIONS		09/18/2023
		f 4 battery backup emergency			TAKEN:		
	_	nonthly for 30 seconds and			1.On 09/15/2023 the		
	-	nutes. Section 7.9.3.1.1 (1)			Maintenance Supervisor/design	-	
	_	testing shall be conducted			conducted the monthly and ar		
	-	nimum of 3 weeks and a			testing for the battery backup		
		eks between tests, for not less			emergency lights and docume	ented	
) Functional testing shall be			the results on the		
	-	for a minimum of 1 1/2 hours			Battery-Operated Emergency		
		ghting system is battery ritten records of visual			Lights and signs Test Log to r		
					set standards. The Administr		
	for inspection by th	ts shall be kept by the owner			verified the work on 09/15/202	دی	
		leficient practice could affect all			2.ALL OTHERS WITH		
	residents in the faci	•			POTENTIAL TO BE AFFECT	ED:	
		,			1.All residents and all sta		
	Findings include:				and visitors have the potentia		
	Ü				be affected but none were.		
	Based on records re	eview with the Maintenance			3.MEASURES TO PREVEN	Т	
	Tech (MT) on 08/2	9/23 at 11:30 a.m., annual			REOCCURRENCE:		
	testing for the batte	ry backup emergency lights			1.On 09/15/2023 the		
		The Battery Operated			Administrator in serviced the		
		est Log indicated the last			Maintenance Supervisor/design	-	
		esting for the 4 battery backup			on the requirement to provide		
		vas conducted on 01/22. The			maintain emergency lighting a		
	-	ice log for the 30 second test			conduct the monthly and annu		
	for the battery backup emergency light was				testing and document the resi	ults	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023	
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY WEST	1720 /	ADDRESS, CITY, STATE, ZIP COD ALBER ST ASH, IN 46992	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	missing for August and July 2023. Bas of records review, the monthly 30 second minute testing for the emergency lights has these findings were	through December of 2022 ed on an interview at the time he MT stated the missing tests identified and annual 90 ne six battery backup as not been conducted.	TAG	to meet set standards. 2.Maintenance Supervisor/designee will ensiprovide and maintain emerge lighting and conduct the monand annual testing as a part of facility's Preventive Maintenane Program and document those tests on the Battery-Operated Emergency Lights and signs Log and will maintain emerge lighting to meet set standards any issues are discovered, the will be addressed and resolved immediately. The Maintenane Supervisor/designee will review with the Administrator the	DATE DATE DATE DATE DATE DATE DATE
				inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECT ACTION:	
				1.The inspection results be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performar Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure	ance e thly ace g. by on as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		A. BU	A. BUILDING <u>01</u> COM		COMPL	DATE SURVEY COMPLETED 08/29/2023	
	PROVIDER OR SUPPLIER S OF WABASH SKI	LLED NURSING FACILITY WEST		1720 Al	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage				compliance is maintained. This plan of correction constitutes our credible allegation of compliance wir all regulatory requirements. Our date of compliance is 09/18/2023.		
Diag. 01	2012 EXISTING Exit and directions accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6	less than 30 occupants exit travel is obvious.)					
	failed to install exit kitchen in accordant 7.10.1.2.1 exits, oth that obviously and shall be marked by readily visible from LSC 7.10.1.2.2 stategress path within a marked by approve where the continual obvious. This defic kitchen staff. Findings include: Based on observation (MT) on 08/29/23 a outside from the kit	on and interview; the facility signage in 1 of 2 exits in the ce with LSC 7.10. LSC ter than main exterior exit doors clearly are identifiable as exits, an approved sign that is any direction of exit access. The exit enclosure shall be dexit or directional exit signs are identifiable as exits, an approved sign that is any direction of exit access. The exit enclosure shall be dexit or directional exit signs are identifiable as exit on of the egress path is not been practice could affect 5.	K 02	293	1. CORRECTIVE ACTION TAKEN: a. On 09/15/2023 the Maintenance Supervisor/desi installed a sign that states Not Exit at the exit door leading outside from the kitchen stora room to meet set standards. Administrator verified the wor 09/15/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potentiabe affected but none were. 3. MEASURES TO PREV REOCCURRENCE: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/desi	gnee ot an age The k on EED: aff	09/18/2023

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	(X2) MULTIPLE CO A. BUILDING B. WING		nstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2023	
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY WEST		1720 AL	DDRESS, CITY, STATE, ZIP COD BER ST H, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	outside exit door in storage room exit do would not allow any exit. Based on inter observation, the MT aforementioned con path of egress was r	the kitchen is obvious but the cor window was painted which wone to see that it is an outside view at the time of acknowledged the dition and confirmed that the not obvious.			on the requirement to ensure to provide and maintain exit and directional exit signs to mark expaths to reach the exits and in serviced him on exits that are considered to be emergency exit to meet set standards. b. Maintenance Supervisor/designee will condition monthly check of all emergency exit signs and non-exiting door and document those inspection results on the Emergency Light & Signs Test Log as a part of the facility's Preventive Maintenant Program. If any issues are discovered, they will be address and resolved immediately. The Maintenance Supervisor/design will review with the Administration 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 we be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with	not exits uct a cy rs n ats the ace seed e ince tor vill nace	

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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			ETED	
		155627	B. WING 08/29/2023			2023	
	ROVIDER OR SUPPLIER	LLED NURSING FACILITY WEST		1720 AL	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0321 SS=E Bldg. 01		- Enclosure are protected by a fire			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 09/18/2023.	s	
	(with 3/4 hour fire automatic fire extir accordance with 8 approved automatic option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-ado not exceed 48 to the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuelb. Laundries (large	nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of hat are deficient in Automatic Sprinkler					
	•	noms (exceeding 64					ı

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 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 08/29/2023 155627 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1720 ALBER ST WATERS OF WABASH SKILLED NURSING FACILITY WEST WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0321 **CORRECTIVE ACTIONS** 09/18/2023 failed to ensure 1 of 1 storage rooms with large TAKEN: amounts of combustible storage and greater than On 09/15/2023 the a. 50 square feet was protected as a hazardous area. Maintenance Supervisor/designee This deficient practice could affect 10 residents in installed a self-closing device to the area. ensure door self closes and latches into the frame on storage Findings include: room #21 to meet set standards. The Administrator verified the work Based on observation during a tour of the facility on 09/15/2023. with the Maintenance Tech (MT) on 08/29/23 at **ALL OTHERS WITH** 1:50 p.m., storage room #21 contained over 20 POTENTIAL TO BE AFFECTED: boxes of supplies, 5 totes, and furniture, and was All residents and all staff greater than 50 square feet making this a and visitors have the potential to hazardous area. The storage room was not be affected but none were. On protected as a hazardous area because the 09/15/2023 the Maintenance corridor door to the room did not self close and Supervisor/designee inspected all latch when tested. Based on interview at the time hazardous area doors for of observation, the MT agreed the storage room self-closing devices and found no contained a large amount of combustible storage, other negative findings. was larger than 50 square feet, and the corridor **MEASURES TO PREVENT** door to the room did not self-close and latch when REOCCURRENCE: tested. On 09/15/2023 the Administrator in serviced the The finding was reviewed with the Administrator Maintenance and the MT during the exit conference. Supervisor/designee/all staff on the requirement that all hazardous 3.1-19(b)area doors must be protected with a self-closing device and self

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closes and latches into the frame

to meet set standards. Maintenance Supervisor/designee will inspect all hazardous area doors

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023	
		133027	B. WING		00/29/2023
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				LBER ST	
WATERS	S OF WABASH SKI	ILLED NURSING FACILITY WEST	WABAS	SH, IN 46992	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				throughout the facility monthly	to
				ensure there is a self-closing	
				device and the door self close	s
				and latches into the frame as	a
				part of the facility's Preventive	
				Maintenance Program and	
				document those inspection re-	sults
				as appropriate. If any issues	I
				discovered, they will be addre	I
				and resolved immediately. Th	ie
				Maintenance Supervisor/design	gnee
				will review with the Administra	tor
				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 v	
				be presented by the Maintena	nce
				Supervisor/designee to the	
				Administrator monthly and the	
				Administrator will present the	-h.
				inspection results at the month	- I
				Quality Assurance/Performan	
				Improvement (QA/PI) meeting	I
				Inspection results and system	I
				components will be reviewed I the QA/PI Committee with	^{∪y}
				subsequent plans of correction	
				developed and implemented a deemed necessary to ensure	15
				compliance is maintained.	
				I	
				This plan of correction constitutes our credible	
				allegation of compliance with	h
1	I		1	i anegation of compliance with	1

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all regulatory requirements.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023		
	PROVIDER OR SUPPLIE S OF WABASH SK	R ILLED NURSING FACILITY WES	STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
K 0355 SS=E Bldg. 01	installed, inspect accordance with Portable Fire Ext 18.3.5.12, 19.3.5 Based on observat failed to inspect 2 each month. NFPA Extinguishers, Sec extinguishers shall by means of an ele minimum of 30-da	inguishers nguishers are selected, ed, and maintained in NFPA 10, Standard for inguishers.	K 0	355	Our date of compliance is 09/18/2023. 1.CORRECTIVE ACTIONS TAKEN: a. On 09/15/2023 the facilities Maintenance Supervisor/designee performed monthly inspection on the two fextinguishers located by room and one located in the dining room.	fire 11	09/18/2023	
	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				and documented the inspection meet set standards. The Administrator verified the work 09/15/2023. 1.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all staff and visitors have the potential to be affected but none were. 2.MEASURES TO PREVENT REOCCURRENCE:	on E D : ff to		

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(6) Indicator for nonrechargeable extinguishers

Section 7.2.4.1 states personnel making manual

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

performing the inspection shall be recorded.

using push to-test pressure indicators.

inspections shall keep records of all fire

performed and the initials of the person

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1.On 09/15/2023 the

Maintenance Supervisor/designee

Administrator in serviced the

that portable fire extinguishers

must be inspected monthly and

Supervisor/designee will ensure

portable fire extinguishers are

documented to meet set

2.Maintenance

standards.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155627	B. W	ING		08/29/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	R			LBER ST		
WATER!	S OF WARASH SKI	LLED NURSING FACILITY WEST			SH, IN 46992		
WAILING		LEED NOROING LAGIETT WEST	,	WADAC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	uires where manual inspections			inspected monthly and		
		ords for manual inspections			documented as a part of the		
	shall be kept on a tag or label attached to the fire				facility's monthly Preventive		
	extinguisher, on an inspection checklist				Maintenance Program and		
	maintained on file, or by an electronic method.				document those inspection re-		
	Section 7.2.4.5 requires records shall be kept to				as appropriate. If any issues		
	demonstrate that at least the last 12 monthly				discovered, they will be addre		
	_	een performed. This deficient			and resolved immediately. Th		
	practice could affect	et up to 15 residents.			Maintenance Supervisor/desig	•	
					will review with the Administra	tor	
	Findings include:				the inspection results.		
					3.The Administrator will		
	Based on observations during a tour of the facility				monitor adherence to the		
		ice Tech (MT) on 08/29/23 at			Preventative Maintenance		
	_	p.m., the monthly inspection tag			schedule and validate the		
	_	ishers, one located by room 11			Preventative Maintenance		
		the Dining room, lacked			documentation is in place.		
		monthly inspection for July			3.MONITORING CORRECT	IVE	
		terview at the time of			ACTION:		
		Γ confirmed the fire			1.The inspection results		
		d by room 11 and in the Dining			be presented by the Maintena	nce	
	_	the July 2023 monthly visual			Supervisor/designee to the		
	inspection.				Administrator monthly and the	!	
					Administrator will present the		
		eviewed with the Administrator			inspection results at the month	-	
	and MT at the exit	conference.			Quality Assurance/Performan		
	2.1.10(1)				Improvement (QA/PI) meeting		
	3.1-19(b)				Inspection results and system		
					components will be reviewed	by	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	15	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible	h	
					allegation of compliance with	11	
					all regulatory requirements.		
					Our date of compliance is		
			1		09/18/2023.		ĺ

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	OF CORRECTION	IDENTIFICATION NUMBER 155627	ILDING	01	COMPL 08/29/	ETED
	ROVIDER OR SUPPLIER	LED NURSING FACILITY WEST	1720 AL	ddress, city, state, zip cod BER ST H, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0363 SS=D Bldg. 01	than required enclexits, or hazardou 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. The apply to auxiliary solid flammable or composition of the door closed with a content of the door closed with a policy of the door closed with a policy of the door release when the compermitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lated the other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/29/2023 155627 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1720 ALBER ST WATERS OF WABASH SKILLED NURSING FACILITY WEST **WABASH, IN 46992** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 **CORRECTIVE ACTIONS** 09/18/2023 1. failed to ensure 1 of 25 corridor doors was TAKEN: provided with a means suitable for keeping the On 09/15/2023 the door closed, had no impediment to closing, Maintenance Supervisor/designee latching and would resist the passage of smoke. relocated the bed so the door This deficient practice could affect 2 residents in would fully close and latch into the room 12. frame in resident sleeping room 12 to meet set standards. The Findings include: Administrator verified the work on 09/15/2023. Based on observation with the Maintenance Tech **ALL OTHERS WITH** (MT) on 08/29/23 at 1:55 p.m., the corridor door to POTENTIAL TO BE AFFECTED: resident sleeping room 12 would not close into the All residents and all staff frame when tested. Based on interview at the time and visitors have the potential to of observation, the MT agreed the corridor door be affected but none were. The to room 12 would not close into the door frame Maintenance Supervisor/designee because the bed was an impediment to closing. inspected all corridor doors to ensure they latch fully into the The finding was reviewed with the Administrator frame and for positive latching and MT during the exit conference. hardware and found no other negative findings. 3.1-19(b) **MEASURES TO PREVENT** REOCCURRENCE: 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. h 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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023			
	ROVIDER OR SUPPLIES OF WABASH SKI	R ILLED NURSING FACILITY WEST		1720 Al	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) the door as a part of the facility Preventive Maintenance Progrand document those inspectio results as appropriate. If any issues are discovered, they wi addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will	y's ram n II be	(X5) COMPLETION DATE
					monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results who be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting	nce nly ce	
					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 09/18/2023.	oy n is	

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			_		•	
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	
		155627	B. WING		08/29/2023	
		<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹				
WATERS	S OF WABASH SKII	LLED NURSING FACILITY WEST		LBER ST SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
K 0500	NFPA 101					
SS=E	Building Services	- Other				
Bldg. 01	Building Services					
J		RKS section any LSC				
		19.5 Building Services				
		are not addressed by the				
		out are deficient. This				
		with the applicable Life				
		FPA standard citation,				
	,	d on Form CMS-2567.				
		on and interview, the facility	K 0500	1. CORRECTIVE ACTION	s 09/18/2023	
		f 2 fuel fired water heaters had	K 0500	TAKEN:	0)/10/2023	
		certificates to ensure the water		a. On 09/14/2023 a Certif	ied	
	_	e operating condition. NFPA		Water Heater Inspector was	lou	
		.3.1 requires all health facilities		contacted to inspect the two f	inol	
		structed, maintained and		fired water heaters in the	uei	
		ze the possibility of a fire			d tha	
	_	ig the evacuation of occupants.		mechanical room and provide	u the	
		ice could affect staff and 10		facility with Certificates of	rdo	
	_			Inspection to meet set standar		
		inity of the two mechanical		The Administrator will verify the	le	
	rooms.			inspections and receipt of the		
	F' 1' ' 1 1			documentation upon		
	Findings include:			completion.		
		0.1 0.11		2. ALL OTHERS WITH	_	
		on during a tour of the facility		POTENTAL TO BE AFFECTE		
		ce Tech (MT) on 08/29/23 at		a. All residents and all stat		
	_	uel fired water heaters in the		and visitors have the potential	to	
		id not have current inspection		be affected but none were.		
	· ·	the fuel fired water heaters had		3. MEASURES TO PREVE	ENT	
		icate with an expiration date of		REOCCURRENCE:		
		n interview at the time of the		a. On 09/15/2023 the		
		Γ agreed the fuel fired water		Administrator in serviced the		
		ertificates were expired or		Maintenance Supervisor/desig	•	
	unavailable.			on the requirement that fuel-fi	I	
			1	water heaters must be inspect		
	_	viewed with the Administrator		and a Certificate of Inspection		
	and MT at the exit	conference.		retained at the facility to meet	set	
				standards.		
	3.1-19(b)			b Maintenance	l	

Supervisor/designee will check all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMP	COMPLETED	
155627 B. WING 08/29	9/2023	
OTDEET ADDRESS CITY OT TE ZID COD		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD		
1720 ALBER ST		
WATERS OF WABASH SKILLED NURSING FACILITY WEST WABASH, IN 46992		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
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 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.	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		A. BUILDING B. WING	construction 01	X3) DATE SURVEY COMPLETED 08/29/2023	
	NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			r address, city, state, zip cod ALBER ST ASH, 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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 1 or was protected. NFP 406.5 (F) Exposed enclosed so that live exposed to contact. affect 10 residents in Findings include: Based on observation with the Maintenant 2:25 p.m., in the soruli of the product of the pr	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility of 1 electrical wiring's in the attic PA 70, 2011 Edition. Article Terminals, Receptacles shall be the wiring terminals are not This deficient practice could on the South hall. The form of the facility on during a tour of the faci	K 0511	1. CORRECTIVE ACTION TAKEN: a. On 09/15/2023 the Maintenance Supervisor/desi installed a cover on the juncti box that had exposed wires ir south end of the attic to meet standards. The Administrator verified the repairs on 09/15/22. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. On 09/15/2023 the Maintenance Supervisor/designee inspected electrical outlets and found not other negative findings. 3. MEASURES TO PREV REOCCURRENCE: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/desi on the requirement that electroutlets must be installed with cover plate to meet set standards.	gnee on n the set r 2023. rED: aff al to on ed all o rENT

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b.

Maintenance

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627			A. BUILDING B. WING	COMPLETED 08/29/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992				
(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		
				Supervisor/designee will inspeal outlet boxes monthly to ensist they have a cover plate and document those inspection resist as appropriate. If any issues discovered, they will be address and resolved immediately. The Maintenance Supervisor/designil review with the Administration 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 who is presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by 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 09/18/2023.	sults are ssed e inee tor ill ince by in s		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155627	B. WI	NG		08/29	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ALBER ST		
WATERS	S OF WABASH SKII	LLED NURSING FACILITY WEST			SH, IN 46992		
			1		1		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BETEERETT		DATE
K 0712 SS=F	NFPA 101						
	Fire Drills						
Bldg. 01	Fire Drills	the transmission of a fine					
		the transmission of a fire					
	-	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						
		view and interview, the facility	K 0	712	1. CORRECTIVE ACTION	S	09/18/2023
		re drills on each shift for 1 of 4	110	, 12	TAKEN:		09/10/2023
		.1.6 states drills shall be			a. On 09/15/2023 the		
	-	on each shift to familiarize			Administrator in serviced the		
		nurses, interns, maintenance			Maintenance Supervisor/design	nee	
	engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.				on the requirement that fire dr	_	
					must be conducted at unexpe		
					times under varying conditions	s at	
					least quarterly on each shift a	nd	
					documented to meet set		
	Findings include:				standards.		
					b. On 09/15/2023 the		
		view with the Maintenance			Maintenance Supervisor/design	•	
		9/23 at 10:30 a.m., the fourth			conducted a fire drill for each		
	-	re drill report was missing			the three shifts and document		
		completed fire drill. There			the results in the facilities Life		1
		fire drills done in the fourth			Safety Binder to meet set		
	_	nterview at the time of record			standards. The Administrate		
		ted the drill was completed but			verified the drills on 09/15/202	<u>'</u> 3.	
	not at the correct tir	ne.			2. ALL OTHERS WITH		
		· · · · · · · · · · · · · · · · · · ·			POTENTIAL TO BE AFFECTI		
		viewed with the Administrator			a. All residents and all sta		
	and MT at the exit conference.				and visitors have the potential	to	

3.1-19(b)

be affected but none were.

MEASURES TO PREVENT

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE		
	3.1.51(c)			REOCCURRENCE: a. Maintenance Supervisor/designee will of fire drills are conducted at unexpected times under viconditions at least quarter each shift and that documbe retained in the facility's Safety Binder as a part of facility's Preventive Maint Program and document the inspection results as approposed in the Administrator will be addressed and resimmediately. The Mainte Supervisor/designee will with the Administrator the inspection results. b. 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 at the main Supervisor/designee to the Administrator will present inspection results at the number of the Qa/PI Committee with subsequent plans of correct developed and implement deemed necessary to enside the prevent of the p	ensure it varying irly on nentation s Life if the tenance hose ropriate. red, they solved enance review e will e e e e e the the the the the the the		

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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> CC			COMPL	COMPLETED	
		155627	B. WING 08/29/2023			2023	
			<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LBER ST		
 WATERS	S OF WARASH SKI	LLED NURSING FACILITY WEST			SH, IN 46992		
WATERC	O WADAON OK	LEED NOROING FACILITY WEST		WADAC	, III 1 0332		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
					compliance is maintained.		
					This plan of correction		
					constitutes our credible	_	
					allegation of compliance with	1	
					all regulatory requirements. Our date of compliance is		
					09/18/2023.		
					03/10/2023.		
K 0920	NFPA 101						
SS=D		ent - Power Cords and					
Bldg. 01	Extens						
	Electrical Equipm	ent - Power Cords and					
	Extension Cords						
	Power strips in a	patient care vicinity are only					
	used for compone						
	•	ed electrical equipment					
	,	les that have been					
		alified personnel and meet					
		10.2.3.6. Power strips in					
	•	cinity may not be used for					
		, personal electronics),					
		m care resident rooms that E. Power strips for PCREE					
		r UL 60601-1. Power strips					
		the patient care rooms					
		y) meet UL 1363. In					
	,	ooms, power strips meet					
	-	ls. All power strips are					
		precautions. Extension					
	_	d as a substitute for fixed					
	wiring of a structu	re. Extension cords used					
	temporarily are re	moved immediately upon					
	completion of the	purpose for which it was					
	installed and mee	ts the conditions of 10.2.4.					
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8					
	, ,	(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 09	920	1. CORRECTIVE ACTION	S	09/18/2023
		f 1 power strip in the Therapy			TAKEN:		
		63. This deficient practice could			a. On 09/15/2023 the		
	affect up to 2 reside	ents.			Maintenance Supervisor/desig	jnee	

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l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		<u>01</u>	COMPLETED		
		155627	B. WING			08/29/	08/29/2023	
	PROVIDER OR SUPPLIER	LED NURSING FACILITY WEST	STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	· E	DATE	
IAU	Findings include: Based on observation (MT) on 08/29/23 at there was a power sub-1363. Based or observation, the MT use in the Therapy rule-1363.	on with the Maintenance Tech t 1:55 p.m., in the Therapy room trip in use that did not meet n interview at the time of agreed a power strip was in room and did not meet		IAU	removed the power strip from a Therapy Room to meet set standards. The Administrator verified the removal of the cord 09/15/2023. 2. ALL OTHERS WITH POTENTAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. Or 09/15/2023 the Maintenance Supervisor/designee inspected rooms throughout the facility for power strips and found no other negative findings. 3. MEASURES TO PREVERECCURRENCE: a. On 09/15/2023 the Administrator in serviced the Maintenance Supervisor/designed and all other staff including the Physical Therapy Department the requirement that power strips are not to be used in the facility meet set standards. b. Maintenance Supervisor/designee will inspeciall 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 approprial fany issues are discovered, the will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. C. The Administrator will	d on D: f to d all or er ENT nee on ips y to ect y chey d e	DAIL	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE		
				monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results we be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to 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.	nce hly ce l. by n			

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