| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155571 | A. BUILDING -- B. WING | 02/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE | 11563 W 300 S DUNKIRK, IN 47336 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 02/27/23<br><br>Facility Number: 000519<br>Provider Number: 155571<br>AIM Number: 100287230<br><br>At this Emergency Preparedness survey, The Waters of Dunkirk Skilled Nursing Facility 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 46 and had a census of 37 at the time of this survey.<br><br>Quality Review completed on 03/01/23 | E 0000 | | |
| E 0039<br>SS=F<br>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)<br>EP Testing Requirements<br>§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).<br><br>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tyisha Wheeler | Administrator | 03/20/2023 |

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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| | (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in | | | |

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| | the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br><br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not | | | |

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| | accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(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 [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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE | | | |

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| | 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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] 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 | | | |

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| | required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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 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 annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(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.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) | | | |

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| | of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(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.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. | | | |

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| | *[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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.<br>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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>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.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or | E 0039 | DISCLAIMER STATEMENT:<br>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.<br><br>Due to the low scope and severity involved with this Survey, we respectful request consideration for a desk review for this Plan of Correction. | 03/27/2023 |

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| | 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.<br>(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.<br><br>Findings include:<br><br>Based on records review with the Administrator on 02/27/23 at 11:45 a.m., there was full documentation for the table top exercise conducted on 03/15/22 but no documentation of a community-based exercise conducted within the last 12 months. Based on interview at the time of records review, the Administrator provided documentation of a facility-based exercise that was completed in January of 2022.<br><br>This finding was reviewed with the Administrator at the exit conference. | | E039 – It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br>On 03/27/23 the Administrator and the Maintenance Supervisor/designee conducted a community-based exercise and completed documentation for the exercise to meet set standards.<br><br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3/16/23 Administrator inserviced the Maintenance Supervisor/designee on the requirement that a table-top exercise and community-based exercise must be conducted annually and documentation retained to meet set standards. Maintenance Supervisor/designee will work with the Administrator to ensure a table-top exercise and community-based exercise is conducted and documented to meet set standards. If any issues are discovered, they will be | |

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| | | | addressed and resolved immediately.<br>The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual 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. | |
| K 0000<br><br>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). | K 0000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155571 | A. BUILDING 01<br>B. WING | 02/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE | 11563 W 300 S<br>DUNKIRK, IN 47336 |

| (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 |
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| | Survey Date: 02/27/2023<br><br>Facility Number: 000519<br>Provider Number: 155571<br>AIM Number: 100287230<br><br>At this Life Safety Code survey, The Waters of Dunkirk Skilled Nursing Facility 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.<br><br>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 operated smoke detectors in the resident rooms. The facility has a capacity of 46 and had a census of 37 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 03/01/23 | | | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT | | | |

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| | LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |

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| | ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 02/27/23 at 12:15 p.m., the exit door at the main entrance and at exit door #6 were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit doors was not posted by the access control pad. | K 0222 | K222 - It is the intent of the facility to ensure means of egress through exit doors are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br>On 02/27/23 the Maintenance Supervisor/designee posted the information on how to obtain the code at exit door #6 to meet set standards. The Administrator verified the posting of the codes on 02/27/23<br><br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were. On 02/27/23 the Maintenance Supervisor/designee inspected all | 03/27/2023 |

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| | The findings were reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | doors to the means of egress to ensure they were readily accessible for use and found no other negative findings.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-27-23 the Administrator inserviced the Maintenance Supervisor/designee and all staff on the requirement that doors must be readily accessible for use to meet set standards.<br>Maintenance Supervisor/designee will inspect all means of egress throughout the facility weekly to ensure doors are readily accessible for use 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.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the | |

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| | | | 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. | |
| K 0345 SS=F Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation with the Maintenance | K 0345 | K345– It is the intent of the facility to ensure fire alarm systems are maintained in accordance with 9.6.1.3 to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN: On 3-9-23 a certified fire alarm contractor/designee repaired the new fire alarm panel to meet set standards. The Administrator verified the installation on 3-9-23<br><br>ALL OTHERS WITH POTENTIAL | 03/20/2023 |

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| | Director on 02/27/23 at 9:10 a.m. during the initial walk through, the fire alarm panel was observed in trouble mode. Based on interview at the time of observation, the Maintenance Director confirmed the issue and stated the repair company ordered a new fire alarm panel on 02/13/23 but it had not arrived yet. The fire alarm system was checked and it was operational.<br><br>This finding was reviewed with the Maintenance Director and Administrator during the exit conference.<br><br>3.1-19(b) | | TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-16-23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire alarm systems must be maintained in accordance with 9.6.1.3 and annual testing and semi-annual visual inspections on the fire alarm system must be performed to meet set standards.<br>Maintenance Supervisor/designee will ensure fire alarm systems are maintained and annual testing and semi-annual visual inspections are performed 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.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION: | |

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| | | | 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. | |
| K 0500 SS=F Bldg. 01 | NFPA 101<br>Building Services - Other<br>Building Services - Other<br>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.<br>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 all staff and residents .<br><br>Findings include: | K 0500 | K500– It is the intent of the facility to ensure fuel-fired water heaters have current inspection certificates to ensure the water heaters are in safe operating condition to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN: On 3-20-23 a Certified Water Heater Inspector inspected the two fuel fired water heaters and provided the facility with Certificates of Inspection to meet | 03/20/2023 |

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| | Based on observation during a tour of the facility with the Maintenance Director on 02/27/23 at 12:50 p.m., the two fuel fired water heaters did not have current documentation but had inspection certificates with an expiration date of 04/26/20. Based on interview at the time of the observation, the Maintenance Director stated the current inspection for the boiler could not be found and agreed the hot water heater inspection was past due.<br><br>This finding was reviewed with the Administrator and the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | set standards. The Administrator verified the inspections and receipt of the documentation on 3-20-23.<br><br>ALL OTHERS WITH POTENTAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were. The facility has only four water heaters.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-16-23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fuel-fired boilers must be inspected and a Certificate of Inspection retained at the facility to meet set standards. Maintenance Supervisor/designee will check all fuel-fired boilers 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.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative | |

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| | | | Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>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. | |
| K 0511<br>SS=D<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>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.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. | K 0511 | K511 – It is the intent of the facility to ensure ground fault circuit interrupter (GFCI) is properly maintained for protection against electric shock to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN: | 03/16/2023 |

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| | This deficient practice could affect 1 resident in the 200 hall shower room.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 02/27/23 at 12:35 p.m., when the GFCI electric receptacle in the 200 hall shower room was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | On 02/27/23 the Maintenance Supervisor/designee replaced the GFCI electric receptacle in the 200 hall shower room to meet set standards. The Administrator verified the installation on 02/27/23<br><br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were. On 02/27/23 the Maintenance Supervisor/designee inspected all electrical outlets within six feet of sinks throughout the facility for GFCI outlets and found no other negative findings.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-16-27 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical outlets within six feet of sinks must be GFCI outlets to meet set standards.<br>Maintenance Supervisor/designee will inspect all outlets within six feet of sinks monthly to ensure they remain working GFCI outlets 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 | |

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| | | | the inspection results.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>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. | |
| K 0741<br>SS=D<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no | | | |

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| | smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br>Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect staff outside exit door #2.<br><br>Findings include:<br><br>Based on observations during a tour of the facility with the Maintenance Director on 02/27/23 at 12:25 p.m., smoking outside exit #2 was evident due to at least 3 cigarette butts on top of a plastic 5-gallon bucket outside of the exit. Based on records review at 11:00, the smoking policy stated smoking is allowed in a designated area on the facility's property. (A covered area about 15 feet from the building) Based on interview at the time of observation and records review, the Maintenance Director stated that outside exit door #2 is not a designated smoking area and confirmed there was evidence of smoking there due to the cigarette butts found outside exit #2 | K 0741 | K741 – It is the intent of the facility to enforce non-smoking policies to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br>On 02-27-23 the Maintenance Supervisor/designee and Housekeeping Supervisor/designee cleaned up the cigarette butts outside exit #2 to meet set standards. The Administrator verified the work on 02-27-23.<br><br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were. The facility has only one smoking area. | 03/27/2023 |

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| | 155571 | A. BUILDING 01<br>B. WING | 02/27/2023 |

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| WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE | 11563 W 300 S<br>DUNKIRK, IN 47336 |

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| | door.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | MEASURES TO PREVENT REOCCURRENCE:<br>On 03/27/23 the Administrator inserviced all staff on the requirement that smoking is allowed in a designated area only and cigarette butts must be put in the metal container with a self-closing device to meet set standards.<br>Maintenance Supervisor/designee and Housekeeping Supervisor/designee will inspect exit #2 to ensure no one is smoking there and will inspect the smoking area weekly to ensure cigarette butts are being put into the metal container with a self-closing device as a part of the facility's Smoking Policy 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.<br>The Administrator will monitor adherence to the Smoking Policy and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the | |

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| | | | 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. | |
| K 0761 SS=F Bldg. 01 | 1) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door | K 0761 | K761 – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 and to ensure proper operation is maintained for the serving doors within the kitchen to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN: On 3-7-23 the Maintenance Supervisor conducted the annual fire door inspections and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation 3-7-23.<br><br>On 3-17-23 the Maintenance | 03/27/2023 |

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| | assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 02/27/23, current documentation of an annual inspection for the fire door assemblies was not available for review. The last record of fire door inspection was completed in 2021. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed | | Supervisor repaired the serving doors from the kitchen so they fully close when released to meet set standards. The Administrator verified the repairs on 3-17-23.<br><br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-27-23 the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee and all staff on the requirement that annual testing & inspections of fire rated doors must be conducted to ensure proper operation and documented on the Annual Door Inspections log and maintained at the facility and the serving doors from the kitchen must fully close when released to meet set standards.<br>Maintenance Supervisor/designee will conduct the annual door inspections to ensure proper operation and document the inspection results on the Annual Door Inspection log 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 | |

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| | within the last year.<br><br>2) Based on observation and interview, the facility failed to ensure proper operation was maintained for 1 of 1 set of serving doors within the kitchen. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. This deficient practice could affect over 10 residents, as well as staff and visitors while in the Dining Room and kitchen staff.<br><br>Findings include:<br><br>Based on observation and interview with the Maintenance Director during the facility inspection on 02/27/23 at 1:20 p.m., the serving doors from the kitchen, that are released automatically by the fire alarm system, did not fully close when released. The Maintenance Director agreed that when tested the serving doors from the kitchen did not fully close.<br><br>These findings were reviewed with the Administrator at the exit conference.<br><br>3.1-19(b) | | and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>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. | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment | | | |

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| | (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<br>Based on observation and interview, the facility failed to ensure 1 of 1 power strip in the Activity room meets UL 1363. This deficient practice could affect up to 12 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 02/27/23 at 12:40 p.m., in the Activity room there was a power strip in use that did not meet UL-1363. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in the Activity room and did not meet UL-1363.<br><br>This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0920 | K920 – It is the intent of the facility to ensure power strips meet UL 1363 to meet set standards.<br><br>CORRECTIVE ACTIONS TAKEN:<br>On 2-27-23 the Maintenance Supervisor/designee removed the power strip from the Activity Room to meet set standards. The Administrator verified the removal on 2-27-23.<br>ALL OTHERS WITH POTENTIAL TO BE AFFECTED:<br>All residents and all staff and visitors have the potential to be affected but none were. On 02-27-23 the Maintenance Supervisor/designee inspected all rooms throughout the facility for | 03/27/2023 |

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| | | | power strips and found no other negative findings.<br><br>MEASURES TO PREVENT REOCCURRENCE:<br>On 3-27-23 the Administrator inserviced the Maintenance Supervisor/designee/all staff that power strips are not to be used as a substitute for fixed wiring to meet set standards.<br>Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use 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.<br>The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br><br>MONITORING CORRECTIVE ACTION:<br>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 | |

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| | | | 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. | |