CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155274	B. WING		04/29/2024	
		L SKILLED NURSING FACILITY, THE STATEMENT OF DEFICIENCIE	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635 PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 04/29 Facility Number: 0 Provider Number: 1002 At this Emergency I Waters of Rockport found in substantial Preparedness Requi Medicaid Participat CFR 483.73	2724 274810 Preparedness survey, The Skilled Nursing Facility was compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 31.	E 0000			
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.0 (e) Emergency and The [LTC facility and	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems.				
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE	

Natalie Walker 05/10/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 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	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	r í	ILDING	NSTRUCTION	(X3) DATE COMPL 04/29 /	ETED
	PROVIDER OR SUPPLIEF	R SKILLED NURSING FACILITY, THI	Ξ	815 W V	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST ORT, IN 47635		
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	1 7	n the emergency plan set (a) of this section.					
	Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an	83.73(e)(1), §485.625(e)(1) ator location. The e located in accordance with rements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA nd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing ng is renovated.					
	Emergency gener The [hospital, CAl implement the em inspection, testing requirements four	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system g, and [maintenance] ad in the Health Care FPA 110, and Life Safety					
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the s it evacuates.					
	§483.73(g), and C The standards inc this section are ap reference by the I Federal Register i	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the n accordance with 5 U.S.C. It part 51. You may obtain					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 04/29/2024	
	PROVIDER OR SUPPLIEI	R SKILLED NURSING FACILITY, T	HE.	815 W V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		the sources listed below.					
		a copy at the CMS urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to: http://www.archives.gov/federal_register/code _of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.						
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 0216						
	1.617.770.3000.						
	(i) NFPA 99, Heal	th Care Facilities Code,					
		ed August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued						
	` '	FPA 99, issued August 9,					
	2012.	CDA 00 issued March 7					
	(IV) TIA 12-4 to NI I 2013.	FPA 99, issued March 7,					
		FPA 99, issued August 1,					
	2013.	17, 00, loddod 7, dgdot 1,					
		FPA 99, issued March 3,					
	2014.						
	(vii) NFPA 101, Li	ife Safety Code, 2012					
	edition, issued Au	•					
	(viii) TIA 12-1 to N 11, 2011.	NFPA 101, issued August					
	(ix) TIA 12-2 to NI 30, 2012.	FPA 101, issued October					
	(x) TIA 12-3 to NF 22, 2013.	FPA 101, issued October					
		FPA 101, issued October					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155274	B. W	NG		04/29	/2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8		1	WASHINGTON ST		
WATERS	OF ROCKPORT S	SKILLED NURSING FACILITY, TH	E		PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG			DATE
		standard for Emergency and					
	, ,	ystems, 2010 edition,					
	including TIAs to chapter 7, issued August 6,						
	2009	,					
	Based on record rev	view and interview, the facility	E 00)41	E041– It is the intent of the facility		05/27/2024
	failed to implement	the emergency power system			to ensure to implement the		
	inspection, testing,	and maintenance requirements			emergency power system		
		Care Facilities Code, NFPA			inspection, testing and		
	· ·	y Code in accordance with 42			maintenance requirements for		
	CFR 483.73(e)(2).				in the Health Care Facilities Code,		
				NFPA 110 and Life Safety Code in			
	Based on record review and interview, the facility				accordance with 42 CFR 483.	73(e)	
	failed to ensure an annual fuel quality test was				(2) to meet set standards.	_	
	performed for 1 of 1 diesel powered generator.				1 CORRECTIVE ACTIONS	S	
		Care Facilities Code, 2012 Edition			TAKEN:		
		states Type 2 EES (Essential generator sets shall be			a On May 10, 2024, the	nad	
		d in accordance with Section			Maintenance Supervisor obtai a copy of the annual fuel quali		
	_	1 6.4.4.1.1.3 states maintenance			test for the diesel generator from	-	
		in accordance with NFPA 110,			the 2/21/24 semiannual	JIII	
	_	gency and Standby Power			inspection/service and		
	_	ion, Chapter 8. NFPA 110,			documented the results in the		
	-	a fuel quality test shall be			facilities Life Safety Binder to		
		annually using tests approved		meet set standards. The			
		s. This deficient practice		Administrator verified the work of		on	
	could affect all resi	dents, as well as staff and			May 10, 2024.		
	visitors.				1 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTE	ED:	
	Findings include:				a All residents and all staff		
					and visitors have the potential	to	
		view on 04/29/24 between 9:30			be affected but none were.		
		. with the Maintenance			2 MEASURES TO PREVE	NT	
	Supervisor present,				REOCCURRENCE:		
		tation of an annual generator			a On May 8, 2024, the		
		lated 08/22/23, and a			Administrator inserviced the		
	_	tor inspection/service dated			Maintenance Supervisor/desig		
	02/21/24, however, there was no documentation of an annual fuel quality test for the diesel generator				on the requirement that an an		
	_	v during the past 12 month			fuel quality test for the emerge generator must be conducted	-	
		nterview at the time of record			documented in the facilities Li		
	I Periou. Dascu oil il	itel them at the time of fection	1		I accommended in the lacillities El		Ī

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/29/2024
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
	SOF ROCKPORT S SUMMARY (EACH DEFICIEN REGULATORY OF review, the Mainter fuel sample was tak semi-annual inspect by the facility's ven not been sent a copy	SKILLED NURSING FACILITY, THE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION nance Supervisor said a diesel ten during the 02/21/24 tion/service of the generator dor, however, the facility has y of the sample report. viewed with the Maintenance	815 W	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) Safety Binder to meet set standards. b The Maintenance Supe /designee will ensure an annufuel quality test for the emerg generator is conducted and documented in the facilities L Safety Binder to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Polymonia and Validate the documentation is in place. 1 MONITORING CORRECTIVE ACTION: a At least every three year the four-hour load test will be completed to ensure compliant the Administrator and Maintenance Supervisor/desi will review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrator present the training results at Quality Assurance/ Performal Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI	rvisor ual ency ife dicy rs nce, gnee and to s or will the nce g. ents
K 0000				Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliants maintained.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155274			JILDING	nstruction 01	(X3) DATE COMPL 04/29 /	ETED	
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE		815 W V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635		
(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
Bldg. 01	A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Date: 04/29 Facility Number: 0 Provider Number: AIM Number: 100/2 At this Life Safety O Rockport Skilled No compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L) Health Care Occupa This one story facility Type V (000) consts sprinklered. The far with hard wired sma and spaces open to a operated smoke alar rooms. The facility census of 31 at the to All areas where the access were sprinkle facility services were detached structures, for a maintenance si	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR 2/24 200174 274810 Code survey, The Waters of cursing Facility was found not in requirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ection Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors the corridors, plus battery rms in all resident sleeping has a capacity of 60 and had a	K 00				
	Quality Review con	npleted on 05/02/24					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		A. B	MULTIPLE CO BUILDING VING	nstruction 01	COMP	E SURVEY PLETED 9/2024	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	HE	815 W V	DDRESS, CITY, STATE, ZIP COD NASHINGTON ST ORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting	corridor openings in other					
	than required end	closures of vertical openings,					
	exits, or hazardou	us areas resist the passage					
	of smoke and are made of 1 3/4 inch						
	solid-bonded core wood or other material						
	capable of resisting fire for at least 20						
		ı fully sprinklered smoke					
		e only required to resist the					
		e. Corridor doors and doors					
	to rooms containi	_					
		erials have positive latching					
		latches are prohibited by					
	_	These requirements do not					
	1	spaces that do not contain					
		nbustible material.					
		en bottom of door and floor					
	_	ceeding 1 inch. Powered					
		with 7.2.1.9 are permissible					
	1 '	device capable of keeping					
		hen a force of 5 lbf is					
	1	no impediment to the					
	_	ors. Hold open devices that door is pushed or pulled are					
		ted protective plates of					
	_ ·	are permitted. Dutch doors					
	_	.6 are permitted. Door					
		abeled and made of steel or					
		compliance with 8.3,					
	unless the smoke	•					
		d fire window assemblies are					
	1 '	n sprinklered compartments					
	1	ictions in area or fire					
	resistance of glas	ss or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPL 04/29/	ETED
	PROVIDER OR SUPPLIEF	SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635		WASHINGTON ST		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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
TAG	Show in REMARK fire protection ration devices, etc. Based on observation failed to ensure 1 or impediment to closs. This deficient pract residents, staff, and Findings include: Based on observation p.m. and 2:30 p.m. the Maintenance Surdoor behind the Nuropen with a two gal there was a 1/4 inched door. Based on observation, the Maintenance of the door. Based on observation, the Maintenance of the door behind the door. Based on observation, the Maintenance of the door behind the door. Based on observation, the Maintenance of the door behind the door observation, the Maintenance of the door behind the door observation, the Maintenance of the door observation observation, the Maintenance of the door observation observa	As details of doors such as angs, automatics closing on and interview, the facility of 2 Med room doors had no ang and was smoke resistant. ice could affect over 20 visitors. The station was held wide a lon container, furthermore, a hole through the middle of interview at the time of the interview at the time of the at two gallon container and rough the door. He further stant Director of Nursing a door being held wide open.	K 0.		K363 – It is the intent of the facility to ensure med room do have no impediment to closing is smoke resistant to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On April 29, 2024, the Maintenance Supervisor/desig removed the two gallon contai and repaired the hole in the eamed room door to meet set standards. The Administrator verified the repairs on April 30 2024. 1 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff and visitors have the potential be affected but none were. 2 MEASURES TO PREVE REOCCURRENCE: a On May 8, 2024, the Administrator in serviced the Maintenance Supervisor/Nurs Staff med rooms doors are no be propped open and must refree of holes to meet set standards. b Maintenance Supervisor/DON/designee will inspect all med room doors to ensure they are not propped on and remain free of holes as a of the facility's Preventive Maintenance Program and document those inspection residents.	oors g and gnee iner ast	05/27/2024

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155274	B. W	ING		04/29/	2024
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THI	Ē	815 W \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
V 0049					as appropriate. If any issues discovered, they will be addres and resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results. c. The Administrator will monited adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is place. 1 MONITORING CORRECTIVE ACTION: a. The inspection results will 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 by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	ssed e gnee tor or s in	
K 0918 SS=C Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterion	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 04/29/2024				ETED	
		133214	D. WI			04/23/	2024
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TH	E	815 W \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	safety and critica	l branches. Maintenance					
	and testing of the	generator and transfer					
		formed in accordance with					
	NFPA 110.						
		re inspected weekly,					
		load 30 minutes 12 times a					
	·	/ intervals, and exercised					
	1	onths for 4 continuous hours.					
		nder load conditions include ated cold start and					
	-	nual transfer of all EES					
		enducted by competent					
		enance and testing of stored					
	_ ·	urces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
	circuit breakers a	re inspected annually, and a					
	program for perio	odically exercising the					
	components is es	stablished according to					
	manufacturer req	uirements. Written records					
	of maintenance a	and testing are maintained					
	1	able. EES electrical panels					
		narked, readily identifiable,					
	1	n normal power circuits.					
		ossibility of damage of the					
		er source is a design					
		new installations.					
	NFPA 111, 700.1	1 (NFPA 99), NFPA 110,					
		eview and interview, the facility	K 09	110	K918 – It is the intent of the		05/27/2024
		annual fuel quality test was	I K U	910	facility to ensure an annual fue	اد	03/2//2024
		1 diesel powered generator.			quality test is performed for die		
	_	Care Facilities Code, 2012 Edition			powered generator to meet se		
	· ·	states Type 2 EES (Essential			standards.	-	
		generator sets shall be			1 CORRECTIVE ACTIONS	8	
	1	ed in accordance with Section			TAKEN:		
	_	on 6.4.4.1.1.3 states maintenance			a On May 10, 2024, the		
	shall be performed	in accordance with NFPA 110,			Maintenance Supervisor obtai	ned	
	Standard for Emer	gency and Standby Power			a copy of the annual fuel quali		
	Systems, 2010 Edi	tion, Chapter 8. NFPA 110,			test for the diesel generator from	om	
	Section 8.3.8 states	s a fuel quality test shall be			the 2/21/24 semiannual		

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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 155274 B. WING 04/29/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 815 W WASHINGTON ST WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE ROCKPORT, IN 47635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE performed at least annually using tests approved inspection/service and by ASTM standards. This deficient practice documented the results in the could affect all residents, as well as staff and facilities Life Safety Binder to visitors. meet set standards. The Administrator verified the work on Findings include: May 10, 2024. **ALL OTHERS WITH** Based on record review on 04/29/24 between 9:30 POTENTIAL TO BE AFFECTED: a.m. and 12:15 p.m. with the Maintenance All residents and all staff Supervisor present, and visitors have the potential to there was documentation of an annual generator be affected but none were. inspection/service dated 08/22/23, and a MEASURES TO PREVENT semi-annual generator inspection/service dated REOCCURRENCE: 02/21/24, however, there was no documentation of The Administrator inserviced an annual fuel quality test for the diesel generator the Maintenance available for review during the past 12 month Supervisor/designee on the period. Based on interview at the time of record requirement that an annual fuel review, the Maintenance Supervisor said a diesel quality test for the emergency fuel sample was taken during the 02/21/24 generator must be conducted and semi-annual inspection/service of the generator documented in the facilities Life by the facility's vendor, however, the facility has Safety Binder to meet set not been sent a copy of the sample report. standards. The Maintenance This finding was reviewed with the Maintenance Supervisor/designee will ensure an Supervisor during the exit conference. annual fuel quality test for the emergency generator is conducted 3.1-19(b) and documented in the facilities Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they

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will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.

The Administrator will monitor adherence to the Preventative Maintenance

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	OF CORRECTION			01	COMPLETED 04/29/2024
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care vic non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity)	d electrical equipment		schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintena Supervisor/designee to the Administrator monthly and 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 by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	nity ce . by

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/29/2024
	PROVIDER OR SUPPLIES	R SKILLED NURSING FACILITY, TH	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION DATE
	This finding was re	eviewed with the Maintenance the exit conference.		power strips and multi plu adapters and found no oth negative findings. 3.MEASURES TO PREV REOCCURRENCE: 1.On May 8, 2024, the Administrator inserviced the Maintenance Supervisor/designee/all of that multi plug adapters at strips are not to be used a substitute for fixed wiring set standards. 2.Maintenance Supervisor/designee will in all rooms throughout the firmonthly to ensure they do have multi plug adapters of strips in use as a part of the facility's Preventive Maintenspection results as approfered in any issues are discover will be addressed and resimmediately. The Maintenspection results. 3.The Administrator the inspection results. 3.The Administrator the inspection results. 3.The Administrator the inspection results. 1.The inspection residuction is in place 4.MONITORING CORRIACTION: 1.The inspection residuction residuction results and validate the preventative Maintenance documentation is in place 4.MONITORING CORRIACTION: 1.The inspection residuction residuc	gener /ENT ne he he ther staff nd power as a to meet nspect facility o not or power ne enance nose opriate. ed, they olved nance review will e c c ECTIVE ults will tenance e e

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274 NAME OF PROVIDER OR SUPPLIER WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635			
PREFIX (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 APPROPRIAT DEFICIENCY) 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.	DATE nly ce . by	Ň

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