PRINTED: 05/06/2025

DEPARTMENT		RM APPROVED IB NO. 0938-039				
	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	300	ET ADDRESS, CITY, STATE, ZIP COD N WASHINGTON ST (ARUSA, IN 46573		
(X4) ID PREFIX TAG E 0000	(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 B CROSS-REFERENCED TO THE APPROPI	E	(X5) COMPLETION DATE
E 0000 Bldg E 0018 SS=F Bldg	conducted by the In accordance with 42 Survey Date: 04/21 Facility Number: 0 Provider Number: 100 At this Emergency Waters of Wakarus found not in complement of the complemen	72025 00521 155582 266980 Preparedness survey, The sa Skilled Nursing Facility was iance with Emergency irements for Medicare and ting Providers and Suppliers, 42 3 certified beds. 109 are dually are and Medicaid; 24 are are only. At the time of the	E 0000	DISCLAIMER STATEMENT Preparation and/or executi of this plan of correction ir general, or this corrective action, does not constitute admission or agreement by facility of the facts alleged conclusions set forth in the statement of deficiencies. plan of correction and spec corrective actions are prep and/or executed in complia with state and federal laws This plan of correction constitutes a written allega of substantial compliance Federal Medicare and Medicaid requirements.	on an y this or is The cific bared ance	
ыиу	failed to ensure em	view and interview, the facility ergency preparedness policies luded a system to track the staff and sheltered residents	E 0018	E018 – It is the intent of the to ensure emergency preparedness policies and procedures include a system	•	05/23/2025

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

in the LTC facility's care during and after an

residents are relocated during the emergency, the

LTC facility must document the specific name and

location of the receiving facility or other location

in accordance with 42 CFR 483.73(b) (2). This

emergency. If on-duty staff and sheltered

TITLE (X6) DATE

track the location of on duty staff

facility's care during and after an

TAKEN:

emergency to meet set standards.

CORRECTIVE ACTIONS

and sheltered residents in the LTC

David Henke **HFA** 05/05/2025

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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	OF CORRECTION	IDENTIFICATION NUMBER 155582	A. BUILDING B. WING		COMPLETED 04/21/2025
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) E COMPLETION DATE
	deficient practice costaff. Findings include: Based on record revand Maintenance Description of the system to track the sheltered residents in during and after an review. Based on in at 11:31 a.m. on 04/policy or procedure staff was available. This finding was revenue of the staff.	riew with the Administrator irector at 11:41 a.m. on es or procedures that included a location of on-duty staff and in the LTC facility's care emergency was available for terview with the Administrator (21/25, he acknowledged no for tracking of residents or viewed with the Administrator irector at the exit conference.		a On 04/28/2025, the Maintenance Supervisor/DON/Administra reviewed and updated the pand procedures in the emerplan to include policies and procedures that include a sy to track the location of on dustaff and sheltered residents LTC facility's care during an an emergency to meet set standards. 2 ALL OTHERS WITH POTENTIAL TO BE AFFEC a All residents and all stavisitors have the potential to affected but none were. 3 MEASURES TO PREV REOCCURRENCE: a On 04/28/2025, he Administrator in serviced the Maintenance Supervisor to to update the policy and procedures annually to inclusystem to track the location duty staff and sheltered resi in the LTC facility's care dur and after an emergency to reset standards. The Administinserviced all staff on the upemergency preparedness pron 04/28/2025. b The Administrator/Maintenance Supervisor/designee will energian supplied to include a system to track the location duty staff and sheltered resi plans annually to include a system to track the location duty staff and sheltered resident	tor olicies gency /stem uty s in the d after TED: off and be ENT E DON/ ensure dde a of on dents ing neet trator dated rogram sure to les and by of on

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	ENTERS FOR MEDICARE & MEDICAID SERVICES							
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	l í	UILDING	ONSTRUCTION	(X3) DATE COMPL 04/21/	LETED	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	HE	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573			
(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)	те	(X5) COMPLETION DATE	
					in the LTC facility's care during and after an emergency to me set standards. Adelia communication system initiate on 04/28/2025, corporate train on 04/27/2025. c The Administrator will monitor adherence to the Emergency Preparedness Pol Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The Administrator and Maintenance Supervisor/design will review the Emergency Preparedness Policy Manual tensure it includes a letter from their natural gas provider to me set standards. Those reviews be documented as appropriate The Administrator will present training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting Results and system component will be reviewed by the QA/PI Committee with subsequent performent of correction developed and implemented as deemed necessary to ensure compliant is maintained. Paper Compliant is requested secondary to no harm or incident.	eet ed ning licy gnee to neet swill e. the		
E 0031 SS=F		6.54(c)(2), 418.113(c)(als Contact Information						

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Based on record review and interview, the facility

failed to ensure the emergency preparedness

SS=F Bldg. --

Event ID:

BGJG21

E 0031

Facility ID: 000521

If continuation sheet

E031 – It is the intent of the facility

to ensure the emergency

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ENTERS FOR	R MEDICARE & MEDIC		OM	IB NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	LETED
		155582	B. W	ING		04/21	
		1.000		_			
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE	WAKA	RUSA, IN 46573		
(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 DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	communication pla	n includes (2) Contact			preparedness communication	plan	
	information for the	following: (i) Federal, State,			includes contact information for	or	
	tribal, regional, or l	local emergency preparedness			the following: federal, State, tr	ibal,	
	staff (ii) The State	Licensing and Certification			regional or local emergency		
	Agency (iii) The O	ffice of the State Long-Term			preparedness staff, the state		
	Care Ombudsman ((iv) Other sources of assistance			licensing and certification agei	ncy,	
	in accordance with	42 CFR 483.475(c)(2). This			the office of the state long term	•	
		ould affect all residents, staff			care ombudsman, other sourc		
	and visitors.				of assistance in accordance w		
					42 CFR 483.73©(2) to meet se		
	Findings include:				standards.		
					1 CORRECTIVE ACTIONS		
	Based on record re-	view with the Administrator			TAKEN:		
	and Maintenance D	Director at 11:31 a.m. on			a On 04/28/2025, the		
	04/21/25, the facility	ty failed to include contact			Administrator and the		
		included the IDOH gateway			Maintenance Supervisor/desig	inee	
		s email as the primary and			reviewed and updated the	,	
		contacting IDOH in the			emergency preparedness		
		etion of the emergency			communication plan to include	<u> </u>	
		manual. Based on interview			contact information which inclu		
		ator at 11:31 a.m. on 04/21/25,			the IDOH gateway website or		
		he information was not			incidents email as the primary	and	
	included in the EP.				alternate means of contacting		
					IDOH in the communication		
	This finding was re	eviewed with the Administrator			section of the emergency		
	_	Director at the exit conference.			preparedness manual to meet	set	
					standards.		
					2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTE	ED:	
					a All residents and all staff		
					visitors have the potential to b		
					affected but none were.	-	
					3 MEASURES TO PREVEN	NT	
					REOCCURRENCE:		
					a On 04/28/2025 the		
					Administrator inserviced the		
					DON/Maintenance Supervisor	/all	
					staff on the requirement to ens		
	I		1		1 State of the requirement to one		I

to review and update the

emergency preparedness policies

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	
		155582	B. WIN	NG		04/21/	/2025
NAME OF B	DOLUDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIEF	· ·		300 N V	VASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, THE	E	WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					annually and to include the ID	OH	
					gateway website or incidents		
					email as the primary and alter	nate	
					means of contacting IDOH in t	:he	
					communication section of the		
					emergency preparedness mar	nual	
					to meet set standards.		
					b DON/Maintenance		
					Supervisor/designee will work	with	
					the Administrator to ensure to		
					review and update the emerge	-	
					preparedness communication	-	
					annually and to include the ID	OH	
					gateway website or incidents email as the primary and alter	nato	
					means of contacting IDOH in t		
					communication section of the	.110	
					emergency preparedness mar	าแลโ	
					to meet set standards. If any		
					issues are discovered, they wi		
					addressed and resolved		
					immediately. The Administr	rator	
					attend the County wide		
					Emergency Drill on 04/23/202	5	
					and inserviced the staff and		
					managers on 04/28/2025.		
					c The Administrator will		
					monitor adherence to the		
					Emergency Preparedness Pol	icy	
					Manual and validate the		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a At least annually to ensu		
					compliance, the Administrator	and	
					DON/Maintenance		
					Supervisor/designee will revie		
					Emergency Preparedness Pol	ıcy	
			1		Manual and conduct required		

exercises and make changes as

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		A. BUILDING CO			(X3) DATE : COMPL 04/21/	ETED
	PROVIDER OR SUPPLIES	R SKILLED NURSING FACILITY, THE	<u> </u>	300 N V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(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)	TE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	Based on record refailed to conduct explan at least twice punannounced staff procedures. The LT following: (i) Particexercise that is cona. When a communaccessible, conduct facility-based function or man-made emer of the emergency pfrom engaging its recommunity-based full-scale functiona the onset of the act (ii) Conduct an addinclude, but is not la. A second full-scale	view and interview, the facility sercises to test the emergency or year, including drills using the emergency TC facility must do the cipate in an annual full-scale munity-based; or nity-based exercise is not an annual individual, cional exercise. Ity experiences an actual natural gency that requires activation lan, the LTC facility is exempt next required full-scale in a per individual, facility-based all exercise for 1 year following ual event. Intional exercise that may imited to the following:	E 00	039	necessary to meet set standar Those reviews will be docume as appropriate. The Administra will present the training results the Quality Assurance/ Performance Improvement (Q meeting. Results and system components will be reviewed if the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. Pay compliance is requested secondary to no harm or incide E039 – It is the intent of the fat to ensure to conduct exercises test the emergency plan at lead twice per year, including unannounced staff drills using emergency procedures to mee set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 04/28/2025, the Administrator and the DON/Maintenance Supervisor/designee conducte full-scale community based exercise, a facility based functional exercise or an actual natural or man-made emerger that requires activation of the emergency plan and documer the information on the after-act report and in the Life Safety B	ented ator s at A/PI) by n as per ent. cility s to ast the et al ncy ated ator strong at al ncy	05/23/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	300 N V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(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	ATF.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	functional exercise.				to meet set standards.		
	b. A mock disaster	drill; or			2 ALL OTHERS WITH		
	c. A tabletop exercise or workshop that is led by a				POTENTIAL TO BE AFFECTI	ED:	
	facilitator that includes a group discussion, using				a All residents and all staff	and	
	a narrated, clinicall	y-relevant emergency scenario,			visitors have the potential to b	e	
	_	n statements, directed			affected but none were.		
		red questions designed to			3 MEASURES TO PREVE	NT	
	challenge an emerg				REOCCURRENCE:		
		ΓC facility's response to and			a On 04/28/2025the		
		ation of all drills, tabletop			Administrator in serviced the I	OON/	
		rgency events, and revise the			Maintenance Supervisor/desig	gnee	
	1	gency plan, as needed in			on the requirement to conduct	t	
	accordance with 42				annual exercises to include a	full	
	This deficient pract	rice could affect all residents,			scale community based exerc	ise,	
	staff and visitors.				a facility based functional exe	rcise	
					or an actual natural or man-m	ade	
	Findings include:				emergency that requires activ	ation	
					of the emergency plan and		
	Based on record rev	view with the Administrator			document on the after-action		
	and Maintenance D	Pirector at 12:10 p.m. on			report and in the Life Safety B	inder	
	04/21/25, the facilit	ty failed to provide			to meet set standards.		
	documentation of a	full-scale community-based			b DON/Maintenance		
	exercise, a facility-	based functional exercise or an			Supervisor/designee will work	with	
		an-made emergency that			the Administrator to ensure to		
	required activation	of the emergency plan. Based			conduct annual exercises to		
		he Administrator at 12:10 p.m.			include a full scale community	,	
		dministrator stated, a full-scale			based exercise, a facility base	ed:	
		exercise, a facility-based			functional exercise or an actua		
	functional exercise	or an actual natural or			natural or man-made emerge	тсу	
		ncy that required activation of			that requires activation of the		
		was not conducted during the			emergency plan and docume		
		ility administrator, and he was			the after-action report and in t		
		onducted in the last 12-month			Life Safety Binder to meet set		
	period.				standards. If any issues are		
					discovered, they will be addre		
	_	viewed with the Administrator			and resolved immediately. Th		
	and Maintenance D	Director at the exit conference.			Administrator attended a full s	cale	
					drill with the Elkhart County		
					Emergency Management		
			1		Department on 04/23/2025.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025
	PROVIDER OR SUPPLIEF	SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE
E 0041 SS=F	, ,	(e), 485.542(e), 485.62 LTC Emergency Power		Certificate attached. The staff were inserviced on the drill or 04/28/2025. c The Administrator will monitor adherence to the Emergency Preparedness Pol Manual and validate the documentation is in place. 4 MONITORING CORRECTIVE ACTION: a At least annually to ensure compliance, the Administrator DON/Maintenance Supervisor/designee will revie Emergency Preparedness Pol Manual and conduct required exercises and make changes necessary to meet set standar Those reviews will be documentated as appropriate. The Administr will present the training result the Quality Assurance/Performance Improvement (Components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. Paragraphical conditions are requested secondary to no harm or incidental conditions.	licy licy are and ew the licy as rds. ented eator s at QA/PI) by n as aper
Bldg	Based on record rev interview; the facili period emergency g	view, observation, and ty failed to document 36-month generator testing for 1 of 1 ors in accordance with NFPA	E 0041	E041– It is the intent of the fa to ensure to document 36-mo period emergency generator testing for emergency genera	nth

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/21/2025		
	PROVIDER OR SUPPLIER	R SKILLED NURSING FACILITY, TH	E	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(X4) ID	SHWMADV	STATEMENT OF DEFICIENCIE	I	ID	I		(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	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1/10		NFPA 99, Health Care Facilities		1710	in accordance with NFPA 99 a	nd	DATE
		, Section 6.4.1.1.6.1 states Type			NFPA 110 to meet set standa		
	1 and Type 2 essential electrical system power				1. CORRECTIVE ACTIONS	us.	
		ll be classified as Type 10,			TAKEN:		
	· · ·	enerator sets per NFPA 110.			a. On 05/23/2025, the certified	l	
	_	ndard for Emergency and			Generator Contractor/Mainten		
		stems, 2010 Edition, Section			Supervisor/designee will cond		
		EPSS shall be tested at least	1		the four-hour load bank testing		
		36 months. Section 8.4.9.1			the facility's emergency gener	•	
	1	S shall be tested continuously			and documented the results in		
		its assigned class (See Section			Life Safety Binder to meet set		
		2 states where the assigned			standards. The Administrator		
	class is greater than 4 hours, it shall be permitted				verify the work on that same of		
	to terminate the test after 4 continuous hours.				2. ALL OTHERS WITH	,	
	Section 8.4.9.5 state	es the minimum load for this			POTENTIAL TO BE AFFECTE	ED:	
	test shall be specific	ed in 8.4.9.5.1, 8.4.9.5.2, or			a All residents and all staff	and	
	8.4.9.5.3. Section 8	3.4.9.5.3 states for spark-ignited			visitors have the potential to b	е	
	EPS's, loading shall	l be the available EPSS load.			affected but none were.		
	This deficient pract	ice could affect all residents,			3. MEASURES TO PREVENT		
	staff and visitors.				REOCCURRENCE:		
					a. On 5/23/2025, the Administ	rator	
	Findings include:				inserviced the Maintenance		
					Supervisor/ designee on the		
		view with the Administrator			requirement to ensure to cond		
		pirector at 10:44 a.m. on			the four-hour load bank testing	-	
	·	tation was not available to			the facility's emergency gener		
	-	eriod load est for 4 continuous			and document the results in th		
		emergency generator. Based			Life Safety Binder to meet set		
		time of record review, the			standards.		
		tor stated the generator service			b The Maintenance		
	_	ned maintenance on the			Supervisor/designee will ensu		
	_	ber and believed the test had			conduct the four-hour load bal		
	been conducted at t				testing on the facility's emerge	нсу	
		generator load test from the endor dated 12/11/2024,			generator and document the		
	~	as for a load bank test and was			results in the Life Safety Binde	a as	
		Based on interview with the			a part of the facility's annual	rom	
		Maintenance Director at 10:44			Preventive Maintenance Prog		
		o other documentation	1		and document those inspection		
		load test within 36 months had			results as appropriate. If any		
	maicaning a 4-nour	ioau iest within 30 months nau	1		issues are discovered, they w	ıı be	1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	•
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	been completed wa			addressed and resolved immediately. The Maintenar Supervisor/designee will revivith the Administrator the inspection results. c The Administrator will monitor adherence to the Emergency Preparedness P. Manual and validate the documentation is in place. 4.MONITORING CORRECT ACTION: a. At least every month the I bank testing will be completed weekly inspection of the ger will be conducted to ensure compliance; the Administrate Maintenance Supervisor/des will review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented appropriate. The Administrate present the training results and system compor will be reviewed by the QA/F Committee with subsequent of correction developed and implemented as deemed necessary to ensure compliates requested secondary to reharm or incident.	roce iew Policy VE oad ed and erator or and signee I and / to as tor will at the ance ng. eents Pl plans ance iance
K 0000					
Bldg. 01					

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155582	B. WI	NG		04/21/	2025
			<u> </u>	CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
\A/ATEDO		NULLED MUDDING FACILITY THE	_		WASHINGTON ST		
WATERS	OF WARARUSA S	SKILLED NURSING FACILITY, THE	L WARAI		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PRECTION (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 APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Life Safety Code	Recertification and State	K 00	000	DISCLAIMER STATEMENT:		
	Licensure Survey w	vas conducted by the Indiana			Preparation and/or execution	1	
	Department of Health in accordance with 42 CFR				of this plan of correction in		
	483.90(a).			general, or this corrective			
	Survey Date: 04/21/2025				action, does not constitute a	n	
					admission or agreement by t	his	
					facility of the facts alleged or	•	
	Facility Number: 00				conclusions set forth in this		
	Provider Number: 1				statement of deficiencies. The		
	AIM Number: 1002	266980			plan of correction and specif		
		~ 1			corrective actions are prepar		
	•	Code survey, The Waters of			and/or executed in compliand	ce	
		Jursing Facility was found not			with state and federal laws.		
	•	Requirements for Participation			This plan of correction		
		aid, 42 CFR 483.90(a), Life			constitutes a written allegation		
	-	d the 2012 edition of the			of substantial compliance wi	th	
		etion Association (NFPA) 101,			Federal Medicare and		
		LSC), Chapter 19, Existing			Medicaid requirements.		
	Health Care Occupa	ancies.					
	This one-story facil	ity was determined to be of					
		ruction and was fully					
		cility has a fire alarm system					
		on in the corridors and in areas					
		rs. 73 resident rooms were					
	-	ry operated smoke detectors.					
	The facility is partia						
		kW emergency generator. The					
	_	tified beds. 109 are dually					
	_	are and Medicaid; 24 are					
	certified for Medica	are only. At the time of the					
	survey, the census v	-					
	-						
	Quality Review con	npleted on 04/23/25					
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01							
		on and interview, the facility	K 03	324	K324– It is the intent of the fac	ility	05/23/2025
	failed to maintain 1	of 1 kitchen extinguishing			to ensure to maintain kitchen		

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Event ID:

BGJG21 Facility ID: 000521

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155582	B. WI	NG		04/21/2	2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			VASHINGTON ST		
WATERS	S OF WAKARLISA	SKILLED NURSING FACILITY, TH	F		RUSA, IN 46573		
WITEIRE	01 771101110071	CRIELED HOROING FACILITY, TH		VV/ (I O (I			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	•	nce with NFPA 96, Standard for			extinguishing system in		
		re Protection of Commercial			accordance with NFPA 96,		
		ns, Section 10.5.1 states A			Standard for ventilation and fire		
		means for manual activation			protection of commercial cook	•	
		tween 42 in. and 48 in. above			operations to meet set standa	rds.	
	· ·	sible in the event of a fire, be			1. CORRECTIVE ACTIONS		
	•	f egress, and clearly identify the			TAKEN:	_	
	-	Additionally, NFPA 101, Life			a. Will complete on 5/23/202		
	-	2.3 states that existing life safety the public, if not required by			the facilities licensed fire alarm		
		either maintained or removed.			contractor will relocate the An	I	
		tice could affect kitchen staff			set standards. The Administra		
	only.	tice could affect kitchen staff			will verify the work on the sam	I	
	omy.				day.	ie	
	Findings include:				2. ALL OTHERS WITH		
	i mamga meraac.				POTENTIAL TO BE AFFECTE	=D·	
	Based on observati	ion with the Maintenance			a. All residents and all staff a		
		o.m. on 04/21/2025, the ANSUL			visitors have the potential to b		
	_	mounted 57 inches above the			affected but none were.		
		the path of egress of the			3. MEASURES TO PREVENT		
		interview at 12:43 p.m., the			REOCCURRENCE:		
	Maintenance Direc	etor acknowledged the			a. The Administrator in service	ed	
	measurement as m	easured with a tape measure.			the Maintenance Supervisor/a	ıll	
					dietary staff/designee to ensu	re to	
	This finding was re	eviewed with the Administrator			maintain kitchen extinguishing	1	
	and Maintenance I	Director at the exit conference.			system including the ansul pul	II	
					station in the kitchen to meet s	set	
	3.1-19(b)				standards on 3/23/2025.		
					b. The Maintenance Superviso	or	
					and Dietary Manager will ensu	ure to	
					maintain kitchen extinguishing		
					system including the ansul pu		
					station in the kitchen as a part		
					the facility's monthly Preventiv	/e	
					Maintenance Program and	.	
					document those inspection res		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. The		
					Maintenance Supervisor/desig	gnee	

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/21/2025				
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573					
(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)	(X5) COMPLETION DATE			
				will review with the Administrathe inspection results. c. The Administrator will monical adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is place. 4. MONITORING CORRECTIVACTION: a. The monitoring results will be presented by the Administrato 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 a deemed necessary to ensure compliance is maintained. Paper compliance is requested no harm or incident was noted	tor is in iE ie r at by n s d as			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm Systen	n - Out of Service						
	failed to provide a devent the fire alarm out-of-service for 4 period in accordance. This deficient pract and visitors. Findings include: Based on record rev	view and interview, the facility complete written policy in the system has to be placed hours or more in a 24-hour se with LSC, Section 9.6.1.6. ice affects all residents, staff	K 0346	K346– It is the intent of the factor to ensure to provide a complete written policy in the event the factor alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.6 to meet set standards 1 CORRECTIVE ACTIONS TAKEN: a On 04/28/2025, the Administrator/Maintenance	re Fire			

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Event ID:

BGJG21

Facility ID: 000521

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	300 N W	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST USA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	04/21/25, the fire w contacting the India the IDOH Gateway https://gateway.isdhor by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g the Administrator a 11:29 a.m. on 04/21 acknowledged the frontact information.	atch plan failed to include na Department of Health via link at .in.gov as the primary method method when the IDOH rational by completing the form and e-mailing it to yov. Based on interview with and Maintenance Director at /25, the Administrator fire watch plan did not include		100	Supervisor updated the fire waplan to include contacting the Indiana Department of Health the IDOH Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method when the II Gateway is nonoperational by completing the Incident Report Form and emailing it to incidents@isdh.in.gov to meet standards. The Administrator verified the work on 04/28/202. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff visitors have the potential to b affected but none were. 3 MEASURES TO PREVEI REOCCURRENCE: a On 04/28/2025, the Administrator in serviced the Maintenance Supervisor/DON staff on the requirement to ensithe fire watch plan is fully updated meet set standards. b Maintenance Supervisor/DON/designee will ensure the fire watch plan is fully updated as a part of the facility monthly Preventive Maintenance Program and document those inspection results as approprial fany issues are discovered, the will be addressed and resolve immediately. The Maintenance Supervisor/designee will review the inspection results of the inspection results.	via the DOH ting t set 25 ED: and e NT /All sure ated ully y's nce they d se	DATE

PRINTED: 05/06/2025 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155582	B. W		01	04/21/		
		100002	D			0 1/2 1/	2020	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST			
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, T	HE.		RUSA, IN 46573			
(X4) ID		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 APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	c The Administrator will		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 wil			
					presented by the Maintenance			
					Supervisor/designee to the Administrator monthly and the			
					Administrator will present the			
					inspection results at the month	nlv		
					Quality Assurance/Performance	•		
					Improvement (QA/PI) meeting.			
					Inspection results and system			
					components will be reviewed by	у		
					the QA/PI Committee with			
					subsequent plans of correction			
					developed and implemented a	S		
					deemed necessary to ensure			
					compliance is maintained. Pap	er		
					Compliance is requested secondary to no harm or incide	ant		
					recorded.	JI IL		
K 0353	NFPA 101							
SS=F	Sprinkler System	- Maintenance and Testing						
Bldg. 01								
		review, the facility failed to	K 0	353	K353 – It is the intent of the		05/23/2025	
		t sprinkler system in accordance			facility to ensure to maintain th	ie		
		andard for the Inspection, tenance of Water-Based Fire			wet sprinkler systems in			
		s, Section 5.3.4. Section 5.3.4			accordance with NFPA 25, Standard for the inspection,			
		zing point of solutions in			testing and maintenance of wa	ater		
		tested annually by measuring			based fire protection systems,			
		with a hydrometer or			section 5.3.4 and to ensure			
		adjusting the solution if			automatic sprinkler piping			
		ficient practice could affect all			systems are examined for inte	rnal		

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Event ID:

BGJG21 Facility ID: 000521

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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. BU	JILDING	01	COMPL	ETED
		155582	B. WI			04/21/	
				_			
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
			_		WASHINGTON ST		
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, THI	E	WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	residents, staff and	visitors.			obstructions where conditions		
					exist that could cause obstruc	ted	
	Findings include:				piping as required by NFPA 2	5.	
					2011 edition, the standards for		
	Based on record rev	view and interview with the			inspection testing and		
	Administrator and l	Maintenance Director at 9:37			maintenance of water based fi	ire	
		page 2 of 4 of the sprinkler			protection system, section 14.		
	inspection dated 03/05/2025 from the sprinkler				to meet set standards.		
	vendor, indicated that the antifreeze solution				1.CORRECTIVE ACTIONS		
	system was tested and left in satisfactory				TAKEN:		
	condition; however, the document did not include				1.On 05/23/2025, the		
	the freezing point. In accordance with NFPA 25				licensed sprinkler contractor		
	Figure A.5.3.4.1 the solution should be adjusted				resubmitted their paperwork		
	to -10 degrees Fahrenheit. Based on interview at				showing the proper freeze poi	nt to	
	_	25, the Maintenance Director			meet set standards. The		
		had an antifreeze sprinkler			Administrator verified the work	con	
		ed the antifreeze solution of			05/05/2025.	. 011	
	the generator.				2.On 04/25/2025, the		
	g				Licensed Sprinkler		
	2. Based on record	review and interview, the			Contractor/Maintenance		
		sure 1 of 1 automatic sprinkler			Supervisor conducted the inte	rnal	
	1	examined for internal			pipe inspection of the wet pipe		
		conditions exist that could			system and documented the		
		ping as required by NFPA 25,			results in the facilities Life Safe	etv	
		tandards for the Inspection,			Binder to meet set standards.	,	
		enance of Water-Based Fire			The Administrator verified the	work	
	_	, Section 14.2.1. Section 14.2.1			on 04/25/2025.		
	1	iscussed in 14.2.1.1 and			2. ALL OTHERS WITH		
	_	ion of piping and branch line			POTENTIAL TO BE AFFECTE	ED:	
	_	conducted every 5 years by			1.All residents and all sta	ff	
		connection at the end of one			and visitors have the potential	to	
		ing a sprinkler toward the end			be affected but none were.		
	· ·	for the purpose of inspecting			3.MEASURES TO PREVEN	Т	
		foreign organic and inorganic			REOCCURRENCE:		
	material. This deficient practice affects all				1.On 04/28/2025, the		
	residents, staff and visitors.				Administrator in serviced the		
	,				Maintenance Supervisor/desig	nee	
	Findings include:				on the requirement to ensure		
					maintain the sprinkler system		
	Based on record rev	view with the Administrator			the requirements of NFPA 25	-	
	1		1		10401101110 01 111 1 /1 20	u	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025		
		ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE		300 N W	DDRESS, CITY, STATE, ZIP COD /ASHINGTON ST USA, IN 46573		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	IAU	and Maintenance D 04/21/2025, no doce inspection of the we facility was availab interview with the A Director at 10:15 a.: Administrator advis to contact the sprint request documentat inspection. Based o with the Administra at 11:55 a.m. on 04/ Director provided d "SPRINKLER: FIV INSPECTION" that Maintenance Direct dated 04/21/2025 fr they scheduled a five to be conducted on	irector at 10:15 a.m. on amentation of an internal pipe bet pipe system located in the le for review. Based on Administrator and Maintenance m. on 04/21/2025, the sed the Maintenance Director der vendor immediately and ion of the last internal pipe in record review and interview attor and Maintenance Director (21/2025, the Maintenance Director (21/2025, the Maintenance ocumentation titled: TE YEAR INTERNAL PIPE at was dated 06/18/2019. The for also provided a document from the sprinkler vendor stating the year internal pipe inspection		IAU	to ensure to conduct all inspections and document the results in the facilities Life Safe Binder to meet set standards. 2.Maintenance Supervisor/designee will ensur maintain the sprinkler system in the requirements of NFPA 25 at to ensure to conduct all inspections and document the results in the facilities Life Safe Binder as a part of the facility's Annual Preventive Maintenance Program and document those inspection results as approprial if any issues are discovered, the will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTION: 1.The inspection results where the month of 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	re to per and ety see they deep w	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025		
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THI	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(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
					subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. Participate compliance is requested secondary to no harm or incide recorded.	ns per	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System -	Out of Service					
Bidg. 01	failed to provide a cevent the automatic placed out-of-service 24-hour period in ac 9.7.5. LSC 9.7.6 receprocedures comply the Standard for the Maintenance of Wa Systems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained perpatrol the affected a extinguishers and the fire department consider. During the should not only be 1 sure that the other fibuilding such as egrare available and fur deficient practice country. Findings include: Based on record rev	iew and interview, the facility omplete written policy in the sprinkler system has to be e for 10 hours or more in a ecordance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, Inspection, Testing and ter-Based Fire Protection 15.5.2 requires nine impairment coordinator shall (b) states a fire watch should ersonnel who continuously rea. Ready access to fire e ability to promptly notify are important items to be patrol of the area, the person cooking for fire, but making re protection features of the ress routes and alarm systems anctioning properly. This build affect all residents, staff	K 0	354	k354– It is the intent of the facto ensure to provide correct w policies in the event the autom sprinkler system has to be platout of service for 10 hours or in a 24 hour period in accordate with LSC, Section 9.7.5 to meset standards. 1 CORRECTIVE ACTIONS TAKEN: a On 04/28/2025, the Administrator/Maintenance Supervisor updated the fire we plan to include contacting the Indiana Department of Health the IDOH Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method when the I Gateway is nonoperational by completing the Incident Report Form and emailing it to incidents@isdh.in.gov to mee standards. The Administrator verified the work on 04/28/2025. 2 ALL OTHERS WITH	ritten natic ced more nce et atch via the DOH ting	05/23/2025
		irector at 11:29 a.m. on atch plan failed to include			POTENTIAL TO BE AFFECTE a All residents and all staff		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		A. BUILDING 01 B. WING		COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, TH	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE	
	the IDOH Gateway https://gateway.isdh or by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g the Administrator at 11:29 a.m. on 04/21 acknowledged the fi contact information This finding was rev	nin.gov as the primary method method when the IDOH rational by completing the form and e-mailing it to ov. Based on interview with and Maintenance Director at /25, the Administrator ire watch plan did not include		visitors have the potential to be affected but none were. 3 MEASURES TO PREVERECCURRENCE: a On 04/28/2025, the Administrator in serviced the Maintenance Supervisor/All soon the requirement to ensure fire watch plan is updated to reset standards. b Maintenance Supervisor/designee will ensure the fire watch plan is updated part of the facility's monthly Preventive Maintenance Progund document those inspection results as appropriate. If any issues are discovered, they waddressed 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 with presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system	taff the neet as a ram on fill be	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					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. Pay compliance is requested secondary to no harm or incide reported.	s per	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	Electric					·
	failed to ensure 2 el feet of the outside e with ground fault ci protection against e requires utilities con 9.1.2 requires electromply with NFPA NFPA 70, NEC 201 Circuit-Interrupter I states, ground-fault personnel shall be p 210.8(A) through (Circuit-interrupter slaccessible location. (B) Other Than Dw single-phase, 15- an installed in the location through (8) shall ha circuit-interrupter p (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessible	relling Units. All 125-volt, dd 20-ampere receptacles tions specified in 210.8(B)(1)	K 0:	511	k511– It is the intent of the fact to ensure electrical receptacles within six feet of the outside ed of a sink are provided with grofault interrupter (GFCI) protect against electric shock to meet standards. 1 CORRECTIVE ACTIONS TAKE 2 On 04/25/2025, the Maintenance Supervisor/license electrician installed a GFCI receptacle in the main dining into meet set standards. The Administrator verified the work 04/26/2025. a On 04/25/2025, the Maintenance Supervisor/license electrician installed a GFCI receptacle in the Rehab Hall to meet set standards. The Administrator verified the work 04/26/2025. 3 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff visitors have the potential to be	s dge und ion set sed on on sed on sed	05/23/2025

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155582	B. W	ING		04/21/2025	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			WASHINGTON ST		
WATERS	S OF WAKARUSA	SKILLED NURSING FACILITY, T	HE		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
	deicing, or pipeline	and vessel heating equipment			affected but none were.		
	shall be permitted t	to be installed in accordance			Maintenance Supervisor chec	ked	
	with 426.28 or 427	.22, as applicable.			all other areas and found no o	ther	
	Exception No. 2 to	(4): In industrial establishments			negative findings.		
	only, where the cor	nditions of maintenance and			4 MEASURES TO PREVE	NT	
	supervision ensure	that only qualified personnel			REOCCURRENCE:		
	are involved, an ass	sured equipment grounding			a On 04/28/2025, the		
	conductor program	as specified in 590.6(B)(2)			Administrator inserviced the		
	shall be permitted f	for only those receptacle			Maintenance Supervisor/design	gnee	
	outlets used to supp	ply equipment that would			on the requirement to ensure	the	
	create a greater haz	ard if power is interrupted or			receptacle outlets have groun	ding	
	having a design that	t is not compatible with GFCI			protection in all resident areas	s to	
	protection.				meet set standards.		
	1 1	eceptacles are installed within			b Maintenance		
		outside edge of the sink.			Supervisor/designee will ensu	re	
	_	(5): In industrial laboratories,			the receptacle outlets have		
	_	supply equipment where			grounding protection in all res	ident	
	_	would introduce a greater			areas as a part of the facility's	;	
	hazard shall be per	mitted to be installed without			monthly Preventive Maintenar	nce	
	GFCI protection.				Program and document those		
	_	(5): For receptacles located in			inspection results as appropri	ate.	
		ns of general care or critical			If any issues are discovered,	they	
		care facilities other than those			will be addressed and resolve		
	covered under				immediately. The Maintenand		
		protection shall not be required.			Supervisor/designee will revie	•W	
	(6) Indoor wet loca				with the Administrator the		
	` '	vith associated showering			inspection results.		
	facilities				c The Administrator will		
	- · · · -	e bays, and similar areas where			monitor adherence to the		
	_	c equipment, electrical hand			Preventative Maintenance		
		ghting equipment are to be			schedule and validate the		
	used.				Preventative Maintenance		
	_	tice had the potential to affect			documentation is in place.		
		l visitors in 2 of 7 smoke			5 MONITORING		
	compartments.				CORRECTIVE ACTION:		
					a The inspection results wi		
	Findings include:				presented by the Maintenance	Э	

1.) Based on observation with the Maintenance

Director at 12:34 p.m. on 04/21/25, one electrical

BGJG21

Supervisor/designee to the

Administrator monthly and the

Administrator will present the

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155582	B. WI	NG		04/21	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			VASHINGTON ST		
WATERS	S OF WAKARIISA S	SKILLED NURSING FACILITY, THE	=	WAKARUSA, IN 46573			
	, or written o	THE TOTAL THE PARTY OF THE PART	-	VVAIVAI			
(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 BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	om the edge of the sink in the			inspection results at the month	-	
	-	vas not GFCI protected when			Quality Assurance/Performand		
		al receptacle was a standard			Improvement (QA/PI) meeting		
		ed, failed to interrupt service.			Inspection results and system		
		with the Maintenance Director			components will be reviewed I	ру	
	-	/21/25, he acknowledged the			the QA/PI Committee with	_	
		as not interrupted when tested			subsequent plans of correction		
	with a GFCI tester.				developed and implemented a	IS	
	2) Rosed on observ	ration with the Maintenance			deemed necessary to ensure	nor	
	· ·	m. on 04/21/25, one electrical			compliance is maintained. Pa	-	
	_	om the edge of the sink in the			compliance requested second to no harm or incident occurre	-	
	•	GFCI protected when tested.				u.	
		tacle was a standard type and					
		to interrupt service. Based on					
		Maintenance Assistant at 1:34					
		e acknowledged the electrical					
	_	errupted when tested with a					
	GFCI tester.						
	GI CI testel.						
	This finding was reviewed with the Administrator						
		irector at the exit conference.					
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01							
		view and interview the facility	K 0'	712	K712 –It is the intent of the fac	•	05/23/2025
		re drills in accordance with the			to ensure to conduct fire drills		
	-	PA 101 - 2012 edition, Sections			accordance with the requirement		
		9.7.1, 19.7.1.2, 19.7.1.4 and			of NFPA 101- 2012 edition to	meet	
		cient practice had the potential			set standards.		
	to affect all resident	ts, staff, and visitors.			1 CORRECTIVE ACTIONS		
	Findings 1 1 1				TAKEN:		
	Findings include:				a On 05/05/2025, the		
	1 Dagad an mass = 1	review with the Administrator			Maintenance Supervisor conducted a fire drill on all thre		
						ee	
		irector at 9:37 a.m. on 04/21/25, a first shift fire drill during the			shifts at varying times and	<u>,</u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025			
		ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LOCALISE DEFINITION OF THE PROPERTY OF		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION
	PREFIX TAG	review. Documenta 10/07/2024 indicate 2:45 p.m., this docu first shift; however, Maintenance Direct shift hours are 6:00 of this drill would his shift. 2. Based on record and Maintenance D 04/21/2025, documentation of the data of the	24 was not available for tion of a fire drill dated and a fire drill was conducted at ament also stated it was for a based on interview with the for and Administrator the first a.m. to 2:00 p.m. and the time have been during the second areview with the Administrator irector at 9:42 a.m. on the entation for a third shift fire drill have second quarter of 2024 was contation of a fire drill dated at a fire drill was conducted a fire drill was conducted at		PREFIX TAG	after-action report in the facilit Life Safety Binder to meet set standards. The Administrator verify the work on 05/05/2025. b On 05/06/2025, the Maintenance Supervisor will conduct a fire drill on all three shifts at varying times with a roster of attendees who participated to meet set standards. The Administrator verify the work on 05/07/2025. c On 05/07/2025, the Maintenance Supervisor will conduct a fire drill on all three shifts at varying times with a roster of attendees who participated to meet set standards. The Administrator verify the work on 05/07/2025. c On 05/07/2025, the Maintenance Supervisor will conduct a fire drill on all three shifts at varying times with a roster of attendees who participated and confirmed the alarm signal was received by monitoring company to meet standards. The Administrator verify the work on 05/08/2025. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff visitors have the potential to baffected but none were. 3 MEASURES TO PREVENTIAL TO BE AFFECTE a On 04/28/2028, the Administrator inserviced the Maintenance Supervisor on the requirement to ensure fire drill conducted at the correct time, varying shifts and include a roof attendees and activation of fire alarm system and transmission of the fire alarm signal to meet set standards. b Maintenance	ies will will will ED: and e NT	COMPLETION DATE

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155582		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIES	R SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) N EXERCISE COMPLETION DATE
	REGULATORY OF			Supervisor/Administrator/de will ensure fire drills are con at the correct time, on varying shifts and include a roster of attendees and activation of alarm system and transmiss the fire alarm signal as a part the facility's monthly Prevent Maintenance Program and document those inspection as appropriate. If any issued discovered, they will be add and resolved immediately. Maintenance Supervisor/dewill review with 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 fire drill documents will be presented by the Maintenance Supervisor/deto the Administrator will presert inspection results at the monitor quality Assurance/Performating Improvement (QA/PI) meetic Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct	ation signee trator ation signee trator
				developed and implemented deemed necessary to ensur compliance is maintained. F compliance is requested	re

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025		
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, TH	IE	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(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
					secondary to no harm or incide occurred.	ent	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulation	ons					
	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking occurred. This deficient practice could affect staff outside of the facility near the storage building. Findings include: Based on record review with the Administrator and Maintenance Director at approximately 9:30 a.m. on 04/21/25, the facility provided a copy of the facility's smoking policy that indicated that smoking on the facility property was prohibited. Based on observation with the Maintenance Assistant at 2:04 p.m. on 04/21/2025, a cigarette butt tower was provided next to a bench located near the storage building outside the rear of the facility; however, more than 27 cigarette butts were strewn on the ground around the area of the bench. Based on interview with the Maintenance Assistant he acknowledged there were more than 27 cigarette butts strewn on the ground. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		K 0	741	K741 – It is the intent of the facility to ensure to provide ashtrays and metal containers with self closing cover devices which ashtrays can be emptied noncombustible material and sidesign in outdoor areas where smoking occurs to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 04/27/2025, the Housekeeping Supervisor/ Maintenance Supervisor/Administrator clear up the public way behind the sto meet set standards. The Administrator verified the work 04/27/2025. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff visitors have the potential to b affected but none were. 3 MEASURES TO PREVENT REOCCURRENCE: a On 05/05/2025, the Administrator inserviced all state on the facilities smoking policy meet set standards. b Maintenance Supervisor/Administrator/DON sekeeping Supervisor/designer will conduct weekly inspection	s into d of safe e ned shed c on ED: and e I/Hou	05/23/2025

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE A. BUILDING B. WING	OCONSTRUCTION 01	(X3) DATE COMPL 04/21/	ETED
	NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573			
(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)	ATE	(X5) COMPLETION DATE
				the property of the public way behind the maintenance shed part of the facilities weekly as part of the Smoking Policy. I issues are discovered, they waddressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Sman Policy and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results was presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the monte 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 ensure compliance is maintained. Pacompliance is requested secondary to no harm or incide was reported.	I as a is a is a if any	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical System	s - Essential Electric Syste				
	Based on record rev	view, observation, and	K 0918	K918 - It is the intent of the fa	cility	05/23/2025

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155582	B. WI	NG		04/21/	/2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\\/\TED	WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE				WASHINGTON ST		
WATERS OF WARAROSA SKILLED NORSING FACILITY, THE				WAKAF	RUSA, IN 46573		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interview; the facili	ty failed to document 36-month			to ensure to document 36-mo	nth	
		or load testing for 1 of 1			generator load testing for		
		ors in accordance with NFPA			emergency generators in		
		NFPA 99, Health Care Facilities			accordance with NFPA 99 and	d	
		, Section 6.4.1.1.6.1 states Type			NFPA 110 to meet set standa	rds.	
		tial electrical system power			1 CORRECTIVE ACTIONS	;	
	1 '	ll be classified as Type 10,			TAKEN:		
	_	enerator sets per NFPA 110.			A On 05/19/2025, the		
	· ·	ndard for Emergency and			Maintenance Supervisor/the		
		stems, 2010 Edition, Section			facilities certified generator		
		EPSS shall be tested at least			contractor will conduct the		
		36 months. Section 8.4.9.1			thirty-six-month period emerg	•	
		S shall be tested continuously			generator load testing for four		
		ts assigned class (See Section			hours and documented the re	sults	
	1	2 states where the assigned			in the Life Safety Binder to me	et	
	_	4 hours, it shall be permitted			set standards. The Administra	ator	
		t after 4 continuous hours.			will verify the work on 05/19/2	.025.	
		es the minimum load for this			2 ALL OTHERS WITH		
	-	ed in 8.4.9.5.1, 8.4.9.5.2, or			POTENTIAL TO BE AFFECT	ED:	
		3.4.9.5.3 states for spark-ignited			a All residents and all staff		
	_	l be the available EPSS load.			visitors have the potential to b	е	
	_	ice could affect all residents,			affected but none were.		
	staff and visitors.				3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
	Findings include:				1.On 04/28/2025, the		
					Administrator inserviced the		
		view with the Administrator			Maintenance Supervisor/design	_	
		virector at 10:44 a.m. on			on the requirement to ensure		
		tation was not available to			conduct proper maintenance	and	
	-	eriod load test for 4 continuous			testing of the emergency		
		emergency generator. Based			generator including conductin	_	
		time of record review, the			thirty-six-month load testing for		
		tor stated the generator service			four hours to meet set standa		
	_	ned maintenance on the			b The Maintenance Superv	/isor	
	_	ber and believed the test had			will ensure to conduct proper		
	been conducted at t				maintenance and testing of th		
		generator load test from the			emergency generator includin	-	
	_	endor dated 12/11/2024,			conducting the thirty-six-mont		
		as for a load bank test and was			load testing for four hours to a		
	tested for 1.8 hours	. Based on interview with the			part of the facility's Preventive	;	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPL 04/21		
		155582	B. W	_		04/21/	/2025
NAME OF F	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	E		WASHINGTON ST RUSA, IN 46573		
(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 DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		Maintenance Director at 10:44 to other documentation			Maintenance Program and document those inspection re	culto	
	· · · · · · · · · · · · · · · · · · ·	test within 36 months had			as appropriate. If any issues		
	been completed.	test within 50 months had			discovered, they will be addre		
	been completed.				and resolved immediately. Th		
	This finding was re	viewed with the Administrator			Maintenance Supervisor/desig		
	and Maintenance Director at the exit conference. 3.1-19(b)				will review with the Administra	-	
					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 wi		
					presented by the Maintenance	9	
					Supervisor/designee to the		
					Administrator monthly and the	;	
					Administrator will present the inspection results at the mont	bly	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed		
					the QA/PI Committee with	~)	
					subsequent plans of correctio	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
K 0020	NEDA 404						
K 0920 SS=E	NFPA 101	ont Dower Cords					
SS=E Bldg. 01	Electrical Equipm Extens	ent - Power Cords and					
Blug. UT		on and interview, the facility	K 0	020	K920 – It is the intent of the		05/22/2025
		wible cords were not used as a	K 0	7 2 U	facility to ensure flexible cords	are	05/23/2025
		wiring. LSC 9.1.2 requires			not used as a substitute for fix		
		d equipment shall be in			wiring to meet set standards.	.ou	
	_	FPA 70, National Electrical			1.CORRECTIVE ACTIONS		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE (A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/21/2025
	PROVIDER OR SUPPLIEI	R SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ARUSA, IN 46573	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Code. NFPA 70, 20	011 Edition, Article 400.8		TAKEN:	
	_	s specifically permitted, flexible		1.On 04/21/2025, the	
		all not be used as a substitute		Maintenance Supervisor/design	gnee
	1	a structure. This deficient		removed the three powers str	ips to
	_	et staff in the social services		meet set standards. The	
	office.			Administrator verified the rem	oval
				on 04/21/2025 .	
	Findings include:			2.ALL OTHERS WITH	
				POTENTIAL TO BE AFFECT	
		on with the Maintenance		1.All residents and all sta	
	_	.m. on 04/21/2025, Christmas		and visitors have the potentia	
		wered by a power strip that		be affected but none were. C)n
		second power strip that was		04/21/2025 the Maintenance	
		l power strip that was plugged		Supervisor/designee inspecte	
	_	ele. Based on interview with the		rooms throughout the facility t	
		tor at 12:25 p.m. on 04/21/25, he		power strips and found no oth	ner
	into each other.	multiple power strips plugged		negative findings.	_
	into each other.			3.MEASURES TO PREVEN REOCCURRENCE:	1
	This finding was re	eviewed with the Administrator		1.On the Administrator	
	_	Director at the exit conference.		inserviced the Maintenance	
	and Maintenance B	ricetor at the exit conference.		Supervisor/designee/all other	staff
	3.1-19(b)			that power strips are not to be	
				used as a substitute for fixed	´
				wiring to meet set standards.	
				2.Maintenance	
				Supervisor/designee will inspe	ect
				all rooms throughout the facili	
				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 re	sults
				as appropriate. If any issues	
				discovered, they will be addre	
				and resolved immediately. The	
				Maintenance Supervisor/design	~
				will review with the Administra	ator
				the inspection results.	
			1	3.The Administrator will	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
	155582		B. WI			04/21/	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TH	Ē	300 N V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	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 mont Quality Assurance/Performan 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 ensure compliance is maintained. Pal compliance is requested secondary to no harm or incide was reported.	will ince hly ce J. hly n as	DATE
K 0927 SS=F Bldg. 01		Transfilling Cylinders	K 09	927	K927– It is the intent of the fa	cility	05/23/2025
	facility failed to en storage/transfilling properly working n 99, Health Care Fa 11.5.2.3.1 (2) requi be mechanically ve requires mechanica negative pressure in				to ensure oxygen storage/transfilling rooms are provided with properly working mechanical ventilation and to ensure make up air is provide oxygen storage rooms where oxygen transfilling takes place to ensure oxygen cylinders ar segregated by full and empty are marked to avoid confusion	g d in e and e and	

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05/06/2025 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 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 04/21/2025 155582 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (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 meet set standards. Findings include: **CORRECTIVE ACTIONS** TAKEN: Based on observation with the Maintenance On 04/21/2025, the Director at 1:06 p.m. on 04/21/2025, there was an DON/Maintenance Supervisor exhaust fan in the wall near the ceiling of the replaced the exhaust fan in the oxygen storage/transfilling room; however, it was wall near the ceiling of the oxygen not providing a negative pressure at the time of storage/transfilling room to meet observation. The exhaust fan was making a loud set standards. The Administrator mechanical noise but was not providing a verified the work on 04/21/2025. negative air pressure. Based on interview with the On 05/05/2025 the Maintenance Director at 1:06 p.m. on 04/21/2025, DON/Maintenance Supervisor he acknowledged the oxygen storage/transfilling removed the transition strip down room did not have a fresh air supply and that the to the concrete floor in the oxygen mechanical exhaust fan was not providing a storage/transfilling room to meet negative pressure. set standards. The Administrator verified the work on 05/05/2025. 2.) Based on observation and interview, the On 05/05/2025the facility failed to ensure make-up air was provided DON/Maintenance Supervisor in 1 of 1 oxygen storage rooms where oxygen marked an area for empty transfilling takes place. NFPA 99, Health Care cylinders and marked an area for Facilities Code, 2012 Edition, Section 9.3.7.5.3.7 full containers in the oxygen

states a means of make-up air shall be provided according to one of the following:

(1) Air shall be permitted via noncombustible ductwork to be transferred from adjacent spaces, from outside the building, or from spaces that do not contain combustible or flammable materials via noncombustible ductwork

(2) Air shall be permitted to be transferred from a corridor under the door up to the greater of 24 L/sec (50 cfm) or 15 percent of the room exhaust in accordance with NFPA 90A. Standard for the Installation of Air-Conditioning and Ventilating Systems.

(3) Supply air shall be permitted to be provided from any building ventilation system that does not contain flammable or combustible vapors. This deficient practice could affect all residents, staff and visitors.

storage/transfilling room to meet set standards. The Administrator verified the work on 05/05/2025.

ALL OTHERS WITH POTENTAL TO BE AFFECTED:

- All residents and all staff and visitors have the potential to be affected but none were.
- **MEASURES TO PREVENT** REOCCURRENCE:

1.On 04/23/2025, the Administrator inserviced the DON/and all nursing staff/Maintenance Supervisor to ensure oxygen storage/transfilling rooms are provided with properly working mechanical ventilation and ensure oxygen cylinders are

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPI			COMPL	ETED
155582			B. W			04/21/	
				_			
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					VASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, THI	E	WAKAF	RUSA, IN 46573		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					segregated by fully and empty	to	
	Findings include:				meet set standards.		
					2.Maintenance		
	Based on observation	on with the Maintenance			Supervisor/DON will ensure		
	Director at 1:06 p.n	n. on 04/21/2025, the floor under			oxygen storage/transfilling roo	ms	
	the oxygen storage/	transfilling room had a rubber			are provided with properly wor	king	
		veen the corridor floor and the			mechanical ventilation and en	_	
		e oxygen storage/transfilling			oxygen cylinders are segregat		
		ype transition prevented			by fully and empty as a part of		
		he corridor to the oxygen			facility's Oxygen Policy and		
	-	room. No other means of			Procedures and document the	se	
		oserved in the oxygen			inspection results as appropria		
	•	room. Based on interview with			If any issues are discovered, t		
		irector at 1:06 p.m. on			will be addressed and resolve		
		nowledged no means of			immediately. The Maintenance		
	make-up air was pr	_			Supervisor/DON/designee will		
	1 1				review with the Administrator t		
	3.) Based on observ	vation and interview, the			inspection results.		
	· ·	sure oxygen cylinders were			4 MONITORING		
	-	and empty and were marked to			CORRECTIVE ACTION:		
		FPA 99, Section 11.6.5.2 states,			a The inspection results wi	ll be	
		linders are stored within the			presented by the DON/design		
		npty cylinders shall be			the Administrator monthly and		
		Il cylinders. Section 11.6.5.3			Administrator will present the		
		ers shall be marked to avoid			inspection results at the month	nlv	
		y if a full cylinder is needed in			Quality Assurance/Performand	-	
		is deficient practice could affect			Improvement (QA/PI) meeting		
	all residents and sta	_			Inspection results and system		
	an residents and sa				components will be reviewed I		
	Findings include:				the QA/PI Committee with	Эу	
	i mamga meraac.				subsequent plans of correction	า	
	Based on observation	on with the Maintenance			developed and implemented a		
		n. on 04/21/2025, oxygen			deemed necessary to ensure		
	_	room had more than 10 oxygen			compliance is maintained. Pa	ner	
		· -			•	hei	
	cylinders/containers each that were not marked or separated as full and empty cylinders. Based on				compliance is requested	ont	
	-	Qualified Medication Aide			secondary to no harm or incid	C III	
					was reported.		
		intenance Director at 1:08 p.m.,					
		ating empty and full oxygen					
	cylinders/container	s was available. Based on	1		I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582 NAME OF PROVIDER OR SUPPLIER			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST				
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			E WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIE IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE

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