STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155582	A. BUILDING -- B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 04/21/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/06/2025 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 At this PSR, The Waters of Wakarusa Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 78. Quality Review completed on 06/09/25	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 04/21/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/06/2025 Facility Number: 000521 Provider Number: 155582	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Henke	HFA	06/18/2025

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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	AIM Number: 100266980 At this PSR, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility is partially protected by a diesel-powered 230 kW emergency generator. The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 78. Quality Review completed on 06/09/25		**corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on 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:	K 0741	**K741** – It is the intent of the facility to ensure to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in outdoor areas where smoking occurs to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**:	06/20/2025

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	Based on observation with the Administrator at 9:37 a.m. on 06/06/2025, a cigarette butt tower, a red metal trash can with a non-self-closing cover, and a metal trash can with a plastic self-closing cover was provided next to a bench located outside the rear of the storage building outside the rear of the facility. Based on interview with the Administrator he acknowledged the red trash can did not have a self-closing cover and the other metal trash can had a non-metal plastic self-closing cover. This finding was reviewed with the Administrator at the exit conference. This deficiency was cited on 04/21/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		a On 6/19/2025, the Administrator / Maintenance Supervisor/designee removed the cigarette butt tower and the two metal trash cans and installed a self-closing metal butt container at the rear of the storage building outside the rear of the building to meet set standards. The Administrator verified the work on 6/20/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. Paper compliance is therefore requested. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 6/19/2025, the Administrator inserviced all staff on the facilities smoking policy to meet set standards. b Maintenance Supervisor/Administrator/DON/Housekeeping Supervisor/designee will conduct weekly inspections of the smoking areas to ensure the smoking policy is enforced as a part of the facilities weekly as a part of the Smoking Policy. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Smoking Policy and validate the	

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			Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	