PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/06/2025				
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE				STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST E WAKARUSA, IN 46573					
(X4) ID PREFIX TAG E 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
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.		n his ne ic red ce			
K 0000									
Bldg. 01	Code Recertificatio that exited on 04/21	00521	K 0000)	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. TI plan of correction and specif	n his			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE		

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BGJG22 Facility ID: 000521 If continuation sheet

David Henke

HFA

06/18/2025

PRINTED: 06/19/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			ETED
155582			B. W	ING		06/06	/2025
			•	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		300 N \	WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	iE	WAKAI	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	AIM Number: 1002	266980			corrective actions are prepa	red	
					and/or executed in complian	ce	
		/aters of Wakarusa Skilled			with state and federal laws.		
		as found not in compliance with			This plan of correction		
	Requirements for P	-			constitutes a written allegati		
		l, 42 CFR 483.90(a), Life Safety			of substantial compliance w	ith	
		012 edition of the National Fire			Federal Medicare and		
		tion (NFPA) 101, Life Safety			Medicaid requirements.		
		er 19, Existing Health Care					
	Occupancies.						
K 0741 SS=E							
Bldg. 01	failed to provide as with self-closing co ashtrays can be emp material and safe do where smoking occ	on and interview, the facility htrays and metal containers over devices into which ptied of noncombustible esign in 1 of 1 outdoor areas curred. This deficient practice atside of the facility near the	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 design in outdoor areas where smoking occurs to meet set standards.	s into d of safe	06/20/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

BGJG22 Facility ID: 000521

TAKEN:

1 **CORRECTIVE ACTIONS**

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/19/2025 FORM APPROVED

STATEMENT OF DIFFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER 155582 NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE BEAUTION OF THE PROVIDER OF SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE BEAUTION OF THE PROVIDER OF STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573 TAG ON 0192026, THE Administrator A WASHINGTON ST WAKARUSA, IN 46573 TAG ON 0192026, THE Administrator A WASHINGTON DATE A On 0192026, THE Administrator A WASHINGTON DATE Administrator A WASHINGTON ST WAKARUSA, IN 46573 TAG ON WASHINGTON ST WAKARUSA, IN 46574 TAG ON WASHINGTON ST WAKARUSA, IN 46574 TAG ON WASHINGTON ST WAKARUSA, IN 46574	CENTERS FOR	MEDICARE & MEDIC					OM	B NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE Based on observation with the Padministrator at 9.27 a.m. on 06006/2025, a cigarete but tower, a red metal trash can with a non-self-closing cover, and a metal trash can with a plastic self-closing cover, and individual 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 bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing cover and the other metal trash can bad a non-metal plastic self-closing power. This finding was reviewed with the Administrator at the exit conference. This deficiency was cited on 04/21/2025. The facility fialed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(b) 3.1-19(c) 4.1-19(c) 5.1-19(c) 5.19(c) 6.2-19(c) 6.2-19(c)	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE IX SUMMARY STATEMENT OF DEFICIENCE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AND Based on observation with the Administrator at 9.57 a.m. on 16060/2025, a cigarette butt tower, a red metal trash can with a plastic self-closing cover was provided next to a hench located outside the rear of the storage building outside the rear of the facility. Based on interview with the Administrator at exhavolveliged the red trash can did not have a self-closing cover and the other metal trash can bad 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) STREET ADDRESS. CITY, STATE_ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573 A On 6/19/2025	AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>01</u>			COMPLETED		
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE SIMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAO REGULATORY OR LSC IDENTIFYING DEFORATION REGULATORY OR LSC IDENTIFYING DEFORATION REGULATORY OR LSC IDENTIFYING DEFORATION red metal trash can with a non-self-closing cover, and metal trash can with a non-self-closing cover, and an metal trash can with a non-self-closing cover, and metal trash can with a non-self-closing cover and the other metal trash can had a non-metal plastic 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 deliciency was cited on 04/21/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 300 N WASHINGTON ST WAKARUSA, IN 46573 DA 1900 DEPORTMENT OF THE WARDPROPARTE DEPORTMENT OF THE	155582		B. WI			06/06/2025			
BEGGLATORY OR LSC IDENTIFYING INFORMATION 9:37 a.m. on 06:06:2025, a cigarette but tower, a red metal trash can with a hastic 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. 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) 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) 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) 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) DATE A on 6/19/2025, the Administrator / Maintenance Supervisor/designee removed the cigarette but 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 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 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 metal trash can self-closing metal butt container at the rear of the storage building outside the rear of the building to metal trash can self-closing metal butt container at the rear of the storage building outside the rear of the subditing to metal trash can self-closing metal butt container at the rear of the subditing to metal trash can self-closing metal butt container at the rear of the subditing to metal trash can self-closing metal butt contai	NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573					
9:37 a.m. on 06/06/2025, a cigarette but 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 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. This deficiency was cited on 04/21/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to implement a systemic plan of correction to prevent recurrence. The facility failed to instance and installed a self-closing metal trash cans and ins		*				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE		
monitor adherence to the Smoking	TAG	Based on observation 9:37 a.m. on 06/06/1 red metal trash can and a metal trash can and a metal trash can cover was provided outside the rear of the facility Administrator he action did not have a self-metal trash can had self-closing cover. This finding was reat the exit conference that the exit conference of the facility failed to improve the facility failed to improve the facility failed to prevent the sext conference of the facility failed to improve the facility failed to prevent the facility failed to improve the facility failed to prevent the f	on with the Administrator at 2025, a cigarette butt tower, a with a non-self-closing cover, on with a plastic self-closing next to a bench located he storage building outside sty. Based on interview with the eknowledged the red trash can closing cover and the other a non-metal plastic viewed with the Administrator ce.		IAU	a On 6/19/2025, the Administrator / Maintenance Supervisor/designee removed cigarette butt tower and the tw metal trash cans and installed self-closing metal butt contains the rear of the storage building outside the rear of the building meet set standards. The Administrator verified the work 6/20/2025. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff visitors have the potential to b affected but none were. Pape compliance is therefore reques 3 MEASURES TO PREVEN REOCCURRENCE: a On 6/19/2025, the Administrator inserviced all sta on the facilities smoking policy meet set standards. b Maintenance Supervisor/Administrator/DON sekeeping Supervisor/designe will conduct weekly inspection the smoking areas to ensure ti smoking policy is enforced as part of the facilities weekly as part of the Smoking Policy. If issues are discovered, they wi addressed and resolved immediately. The Maintenanc Supervisor/designee will review with the Administrator the inspection results. c The Administrator will	er at	DATE	

Policy and validate the

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		(X3) DATE SURVEY COMPLETED 06/06/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION DATE	
				Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results will presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	e nlly ce oy		

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