STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/19/2024			ETED		
	ROVIDER OR SUPPLIER	D NURSING FACILITY, THE		317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000	5 September 2024		
	Survey Date: 08/19 Facility Number: 00				Indiana State Department of Health		
	Provider Number: 1 AIM Number: 1002	55039			Attn: Brenda Buroker, Direct of Long Term Care	tor	
	Waters of Peru Skil in compliance with Requirements for M Participating Provid	Preparedness survey, The led Nursing Facility was found Emergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR			2 North Meridian Street Indianapolis, In 46204		
	483.73. The facility census of 30 at the t	•			RE: Survey Event ID EU602	1	
					Dear Ms. Buroker,		
					Please accept the enclosed plan of correction as a credit allegation of compliance to the deficiencies cited during our Life Safety Survey conducted on August 16th, 2024 at Water of Peru. Our latest date of compliance will be September 19th, 2024.	he d er's	
					Hopefully you will find that o	our	

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

TITLE

(X6) DATE

Debra L Coppernoll Administrator 09/05/2024

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: EU6O21 Facility ID: 000014 If continuation sheet Page 1 of 11

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

PRINTED: 09/12/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/19/2024
	PROVIDER OR SUPPLIEI	ED NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970	
(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
				remedies are sufficient. Water's of Peru is respectful requesting paper complianc	-
				If after reviewing our plan o correction, you have questic or require further informatio please do not hesitate to cal me at your convenience at 765-473-4426.	ons n,
				Sincerely,	
				Debbie Coppernoll, HFA Administrator	
K 0000					
Bldg. 01	Licensure Survey v	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000	5 September 2024	
	Survey Date: 08/19	9/24		Indiana State Department of Health	
	Facility Number: (Provider Number: 1002	155039		Attn: Brenda Buroker, Direct of Long Term Care	tor
				2 North Meridian Street	

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

Event ID:

EU6O21 Facility ID: 000014

If continuation sheet

Page 2 of 11

			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155039	B. WI	B. WING 08		08/19/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER	R			AIR PIKE	
WATERS OF PERU SKILLED NURSING FACILITY, THE				IN 46970		
WATERO	OI I LINO SINILLE	D NORSING LACIEIT I, THE		T LINO,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	At this Life Safety	Code survey, The Waters of				
	Peru Skilled Nursin	g Facility was found not in			Indianapolis, In 46204	
	compliance with Re	equirements for Participation in			_	
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),				
	Life Safety from Fi	re and the 2012 edition of the				
	National Fire Protect	ction Association (NFPA) 101,			RE: Survey Event ID EU602	:1
	Life Safety Code (L	SC), Chapter 19, Existing			-	
	Health Care Occupa	ancies and 410 IAC 16.2.				
	This one-story facil	ity was determined to be of			Dear Ms. Buroker,	
	Type II (000) const	ruction and was fully				
	sprinklered. The fac	cility has a fire alarm system				
	with smoke detection	on in the corridors, areas open				
	to the corridors and	battery powered smoke			Please accept the enclosed	
	detection in the resi	dent sleeping rooms. The			plan of correction as a credi	ble
	facility has a capaci	ity of 130 and had a census of			allegation of compliance to t	
	30 at the time of thi	-			deficiencies cited during our	
		•			Life Safety Survey conducte	
	All areas where the	residents have customary			on August 16th, 2024 at Wat	
	access were sprinkl	ered. All areas providing			of Peru. Our latest date of	
	facility services we	re sprinklered.			compliance will be Septemb	er
	•				19th, 2024.	
	Quality Review cor	npleted on 08/22/24				
					Hopefully you will find that	our
					remedies are sufficient.	
					Water's of Peru is respectful	ly
					requesting paper compliance	=
					If after reviewing our plan o	f
					correction, you have question	
					or require further information	
					please do not hesitate to cal	
					me at your convenience at	
					765-473-4426.	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII TIDI E CO	ONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED			
AND PLAN	OF CORRECTION	155039	A. BUILDING B. WING	<u>U I </u>	08/19/2024
		100008	b. wind		00/13/2024
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
WATERS OF PERU SKILLED NURSING FACILITY, THE				AIR PIKE	
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE	PERU,	IN 46970	
(X4) ID		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	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				Sincerely,	
				Debbie Coppernoll, HFA	
				Administrator	
				Administrator	
K 0300	NFPA 101				
SS=F	Protection - Other				
Bldg. 01	Protection - Other				
	List in the REMAR	RKS section any LSC			
	Section 18.3 and	19.3 Protection			
	requirements that	are not addressed by the			
	provided K-tags, b	out are deficient. This			
	-	with the applicable Life			
		FPA standard citation,			
		d on Form CMS-2567.			
		on and interview, the facility	K 0300	K300 – It is the intent of the fa	cility 09/12/2024
	•	of 68 battery operated smoke		to ensure to replace battery	
		resident sleeping rooms in		operated smoke alarms instal	led
		FPA 72. NFPA 72, 2010 Edition,		in resident sleeping rooms in	
		tes unless otherwise		accordance with NFPA 72 to	meet
	-	e manufacturer's published		set standards.	
		and multiple-station smoke		1 CORRECTIVE ACTIONS	
	-	aced when they fail to respond out shall not remain in service		TAKEN: a On 9/5/2024 the	
		s from the date of manufacture.		a On 9/5/2024 the Maintenance Supervisor/design	nnee
		ice could affect all occupants		replaced the battery-operated	
	in the facility.	de could affect all occupants		smoke alarms in all 68 reside	
	in the facility.			sleeping rooms to meet set	
	Findings include:			standards. The Administrator	
	- manage merade.			verified the work on 9/5/2024	
	Based on observation	ons with the Maintenance		2 ALL OTHERS WITH	
		4 during a tour of the facility		POTENTIAL TO BE AFFECT	ED:
		1:48 p.m., manufacturer's		a All residents and all staf	

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

Event ID:

EU6O21

Facility ID: 000014

If continuation sheet

Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	01	COMPLET	ED	
	155039		B. WI)24			
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\A/A TEDC	OF DEDU OKUL E	TO ALLIDOING FACILITY THE			AIR PIKE		
WATERS	OF PERU SKILLE	ED NURSING FACILITY, THE		PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DEAN OF CODDECTION		(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	(COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documentation affix	xed to the underside of the			and visitors have the potential	to	
	battery-operated sm	noke alarms installed in all			be affected but none were.		
	* *	ooms throughout the facility			3 MEASURES TO PREVE	NT	
	indicated the follow				REOCCURRENCE:	`	
		er of the battery-operated			a Maintenance		
	smoke alarm was F				Supervisor/designee will ensu	re all	
	b) The model numb				battery-operated smoke alarm		
		ufacture on all smoke alarms in			are maintained monthly as a p		
	use was December				of the facility's Preventive)ait	
		leeping rooms within the			-	,	
		ne type of battery-operated			Maintenance Program. If any		
	-	em and they were all over 10			issues are discovered, they w addressed and resolved	iii be	
		_					
	years old and neede	-			immediately. The Maintenand		
	Based on interview				Supervisor/designee will revie	w	
		laintenance Director agreed			with the Administrator the		
		smoke alarms were more than			inspection results.		
		eeded to be replaced adding			b The Administrator will		
		them all replaced as soon as			monitor adherence to the		
	he was able to do so	0.			Preventative Maintenance		
					schedule and validate the		
		e reviewed with the			Preventative Maintenance		
		Maintenance Director during			documentation is in place.		
	the exit conference.	•			4 MONITORING		
					CORRECTIVE ACTION:		
	3.1-19(b)				a The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performan	ce	
					Improvement (QA/PI) meeting) <u>.</u>	
					Inspection results and system		
					components will be reviewed		
					the QA/PI Committee with		
					subsequent plans of correctio	n l	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
	l		1		i ilia pian oi contection	1	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D1 COMPLETED 08/19/2024		C MEDICARE & MEDIC				OMB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER WATERS OF PERU SKILLED NURSING FACILITY, THE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (S5) COMPLETION (CAS) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (CAS) (C			î ´		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER WATERS OF PERU SKILLED NURSING FACILITY, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TA	AND PLAN	OF CORRECTION			<u>U1</u>	
WATERS OF PERU SKILLED NURSING FACILITY, THE WATERS OF PERU SKILLED NURSING FACILITY, THE X(4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION X(5) COMPLETION DATE X(6) SSS SEFEROMETO TO SHORE WITH A COMPLETION DATE X(7) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) X(8) ID PROVIDERS FLAND OF CORRECTION (COMPLETION DATE) CONSTITUTE OR COMPLETION DATE CONSTITUTE OR COMPLETION DATE X(8) SS SEFEROM TO THE PROPERTY ACTION SIGNLE BE COMPLETION DATE COMPLETION DAT			100008			00/13/2024
WATERS OF PERU SKILLED NURSING FACILITY, THE PERU, IN 46970 X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG COMPLETION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CONSTITUTE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE X5 CONSTITUTE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE CONSTITUTE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE CONSTITUTE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE CONSTITUTE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OF ACTION SHOULD BE PRECEDED BY FULL REGULAT	NAME OF P	PROVIDER OR SUPPLIEF	₹			
CX4 ID SUMMARY STATEMENT OF DEFICIENCIE ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG Constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/12/2024 K 0353	WATERS	S OF PERILSKILLE	D NURSING FACILITY THE			
PREFIX TAG		ı			11 40070	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION TAG CONSTITUTES OUT COMPILIANCE OF THE PROPERTY OF T					PROVIDER'S PLAN OF CORRECTION	
Constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/12/2024 K 0353 SS=E Bldg. 01 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		`			CROSS-REFERENCED TO THE APPROPRIATE	
R 0353 SS=E Bldg. 01 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	IAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	IAG		DATE
K 0353 SS=E Bldg. 01 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25						
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Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			•			
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Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		•				
Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25						
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c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			_			
Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		b) Who provided	system test			
Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		c) Water system	supply source			
coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		o valor system	supply source			
automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25		Provide in REMAR	RKS information on			
9.7.5, 9.7.7, 9.7.8, and NFPA 25		coverage for any	non-required or partial			
		automatic sprinkle	er system.			
Based on observation, and interview; the facility $K 0353$ K353 – It is the intent of the $09/19/2024$						
			-	K 0353		09/19/2024
failed to ensure 4 of 4 sprinkler heads located facility to ensure sprinkler heads					1	
outside the main entrance in the overhang were located outside the main entrance			-			
dirty and covered in a green corrosion and needed in the overhang are not dirty and		1	•		-	
to be replaced in accordance with NFPA 25. NFPA not covered in corrosion and are in		•				
25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection accordance with NFPA 25 to meet set standards.			-			eı
Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall TAKEN:		-				
be free of corrosion, foreign materials, paint, and 1.On 9/6/2024 facilities		_	-			
physical damage; and shall be installed in the licensed sprinkler contractor will			-			
correct orientation (e.g., up-right, pendent, or repair the four sprinkler beads						

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

sidewall). Furthermore, at 5.2.1.1.2 any sprinkler

Event ID:

EU6O21

Facility ID: 000014

If continuation sheet

located outside the main entrance

Page 6 of 11

09/12/2024 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 08/19/2024 155039 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE that shows signs of any of the following shall be under the facility overhang to meet replaced: set standards. The Administrator (1) Leakage will verify the work on 9/6/2024 (2) Corrosion once completed. (3) Physical Damage 2.ALL OTHERS WITH (4) Loss of fluid in the glass bulb heat responsive POTENTIAL TO BE AFFECTED: element 1.All residents and all staff (5) Loading and visitors have the potential to (6) Painting unless painted by the sprinkler be affected but none were. manufacturer. **3.MEASURES TO PREVENT** In lieu of replacing sprinklers that are loaded with REOCCURRENCE: dust, it is permitted to clean sprinklers with 1.On 9/3/2024 the compressed air or by a vacuum provided that the Administrator in serviced the equipment does not touch the sprinkler. Maintenance Supervisor/designee This deficient practice could affect as many as six on the requirement to ensure all residents, four staff and two visitors. sprinkler heads are maintained and are in accordance with NFPA Findings include: 25 to meet set standards. 2.Maintenance Based on observations with the Maintenance Supervisor/designee will ensure all Director on 08/19/24 during a tour of the facility at sprinkler heads are maintained 12:00 p.m., the four sprinkler heads located and are in accordance with NFPA outside the main entrance under the facility 25 as a part of the facility's overhang were seen to be covered in a green monthly Preventive Maintenance

corrosion and needed to be replaced. Based on interview at the time of observation, the Maintenance Director acknowledged the four sprinkler heads were dirty and added that he would contact his vendor and have them replaced as soon as he could.

This finding was reviewed with the Administrator at the exit conference.

3.1-19(b)

Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the

3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.

inspection results.

4.MONITORING CORRECTIVE ACTION:

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

Event ID:

EU6021

Facility ID: 000014

If continuation sheet

Page 7 of 11

PRINTED: 09/12/2024

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE C	ONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	A. BUILDING 01		COMPL		
		155039	B. WI	NG	08/19/2024		/2024
	PROVIDER OR SUPPLIE	R ED NURSING FACILITY, THE		317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970		
	1						(7/5)
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX				PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	IAU			DATE
					1.The inspection results v		
					be presented by the Maintena	nce	
					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 by	ЭУ	
					the QA/PI Committee with	_	
					subsequent plans of correction		
					developed and implemented a	S	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements.		
					Our date of compliance is		
					9/19/2024.		
K 0511	NFPA 101						
SS=E	Utilities - Gas and	1 Flectric					
Bldg. 01	Utilities - Gas and						
Diag. 01							
		gas or related gas piping PA 54, National Fuel Gas					
		viring and equipment					
	1						
	1	PA 70, National Electric					
		stallations can continue in					
	service provided						
	18.5.1.1, 19.5.1.1						00/10/2021
		on and interview, the facility	K 0:	511	K511– It is the intent of the fac	•	09/19/2024
		of 1 wet location was provided			to ensure wet location is provi		
		ircuit interrupter (GFCI)			with ground fault circuit interru	pter	
	protection against	electric shock. LSC 19.5.1.1			(GFCI) protection against		

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requires utilities comply with Section 9.1. LSC

9.1.2 requires electrical wiring and equipment to

comply with NFPA 70, National Electrical Code.

NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault

Event ID:

EU6O21

Facility ID: 000014

electrical shock to meet set

CORRECTIVE ACTIONS

standards.

TAKEN:

Page 8 of 11 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPL	ETED	
155039		B. W	ING		08/19/	2024	
				CENTER	ADDRESS STEV STATE STR SOD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
WATERO OF REDUCINE ED MUROINO EAGULITY THE				AIR PIKE			
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE		PERU,	IN 46970		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
	Circuit-Interrupter	Protection for Personnel,			a On 9/5/20214 the		
	states, ground-fault	circuit-interruption for			Maintenance Supervisor/desig	jnee	
	personnel shall be p	provided as required in			GFCI in the kitchen and on		
	210.8(A) through (C). The ground-fault			9/9/2024 Maintenance		
	circuit-interrupter s	shall be installed in a readily			Supervisor/designee will direc	t	
	accessible location.				hard wire the ice machine in the	ne	
	(B) Other Than Dv	welling Units. All 125-volt,			dining room to meet set		
	single-phase, 15- ar	nd 20-ampere receptacles			standards. The Administrator		
	installed in the loca	ations specified in 210.8(B)(1)			verified the work on 9/5/2024	and	
	through (8) shall ha	eve ground-fault			will verify the ice machine on		
	circuit-interrupter p	protection for personnel.			9/9/2024.		
	(1) Bathrooms				2 ALL OTHERS WITH		
	(2) Kitchens				POTENTIAL TO BE AFFECTE	ED:	
	(3) Rooftops				a All residents and all staff		
	(4) Outdoors				and visitors have the potential	to	
					be affected but none were.		
	Exception No. 1 to	(3) and (4): Receptacles that are			3 MEASURES TO PREVE	NT	
	not readily accessib	ole and are supplied by a			REOCCURRENCE:		
	branch circuit dedic	cated to electric snow-melting,			a On 9/3/2024 the		
	deicing, or pipeline	and vessel heating equipment			Administrator in-serviced the		
	shall be permitted t	to be installed in accordance			Maintenance Supervisor/desig	nee	
	with 426.28 or 427	.22, as applicable.			on the requirement that wet		
					locations must be provided wi	th	
	Exception No. 2 to	(4): In industrial establishments			ground fault circuit interrupter		
	only, where the cor	nditions of maintenance and			(GFCI) protection against		
	_	that only qualified personnel			electrical shock to meet set		
	are involved, an ass	sured equipment grounding			standards.		
		as specified in 590.6(B)(2)			b Maintenance		
	_	for only those receptacle			Supervisor/designee will inspe	ect	
	outlets used to supp	ply equipment that would			all wet locations monthly to		
	create a greater haz	ard if power is interrupted or			ensure they are provided with		
	having a design that	t is not compatible with GFCI			ground fault circuit interrupter		
	protection.				(GFCI) protection against		
	1 1	eceptacles are installed within			electrical shock as a part of th	е	
	1.8 m (6 ft.) of the	outside edge of the sink.			facility's Preventive Maintenar	nce	
					Program and document those		
	Exception No. 1 to	(5): In industrial laboratories,			inspection results as appropria		
	receptacles used to	supply equipment where			If any issues are discovered, t	hey	
	removal of power v	would introduce a greater			will be addressed and resolve	-	
	hazard shall be peri	mitted to be installed without			immediately. The Maintenand	e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u> COM		LETED
		155039	B. W	ING		08/19/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			AIR PIKE		
\\\\\TEDG	OE DEDITORILLE	ED NURSING FACILITY, THE			IN 46970		
WATERS	OF PERU SKILLE	ED NORSING FACILITY, THE		PERU,	111 40970		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	GFCI protection.				Supervisor/designee will revie	:W	
					with the Administrator the		
	Exception No. 2 to	(5): For receptacles located in			inspection results.		
	patient bed location	ns of general care or critical			c The Administrator will		
	care areas of health	care facilities other than those			monitor adherence to the		
	covered under				Preventative Maintenance		
		protection shall not be required.			schedule and validate the		
	(6) Indoor wet loca				Preventative Maintenance		
	1 ' '	vith associated showering			documentation is in place.		
	facilities				4 MONITORING		
	(8) Garages, service	e bays, and similar areas where			CORRECTIVE ACTION:		
	electrical diagnostic	c equipment, electrical hand			a The inspection results w	/ill	
	tools, or portable li	ghting equipment are to be			be presented by the Maintena	ince	
	used.				Supervisor/designee to the		
					Administrator monthly and the	;	
	NFPA 70, 517-20 V	Wet Locations, requires all			Administrator will present the		
	receptacles and fixe	ed equipment within the area of			inspection results at the mont	hly	
	the wet location to	have ground-fault circuit			Quality Assurance/Performan	ce	
		protection. Note: Moisture can			Improvement (QA/PI) meeting	J.	
		resistance of the body, and			Inspection results and system	I	
		n is more subject to failure. This			components will be reviewed	by	
	_	ould affect as many as 20			the QA/PI Committee with		
	residents, 6 staff an	nd 2 visitors in the dining room.			subsequent plans of correctio		
					developed and implemented a	as	
	Findings include:				deemed necessary to ensure		
					compliance is maintained.		
		ons with the Maintenance			This plan of correction		
		24 during a tour of the facility at			constitutes our credible		
	_	hen / main dining room ice			allegation of compliance wit	h	
		ged into an outlet to the side of			all regulatory requirements.		
	_	he ice machine was plugged			Our date of compliance is		
	•	led with ground fault circuit			9/19/2024.		
) and had three water lines all					
		f the electric outlet. Based on					
		ne of observation, the					
		tor acknowledged the ice					
		FCI protected adding that he					
		stalled as soon as he was able					
	to do so.						
	I		1		I		1

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

PRINTED: 09/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155039	B. WI	NG		08/19/2024	
	PROVIDER OR SUPPLIER	D NURSING FACILITY, THE		317 BL/	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This finding was rev	viewed with the Administrator					
	at the exit conference	ee.					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EU6O21 Facility ID: 000014 If continuation sheet Page 11 of 11