PRINTED: 07/23/2024

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/01/2024		
	PROVIDER OR SUPPLIER			1500 G	ADDRESS, CITY, STATE, ZIP COD SRANT ST			
WATERS	S OF HUNTINGTON	SKILLED NURSING FACILITY,	THE	HUNTI	NGTON, IN 46750	1 46750		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000								
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/01/2024 Facility Number: 000020 Provider Number: 155059 AIM Number: 100288696 At this Emergency Preparedness survey, The Waters of Huntington 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 a capacity of 85 and had a census of 46 at the time of this survey. Quality Review conducted on 07/02/24		E 00	000	DISCLAIMER STATEMENT: Preparation and/or execution this plan of correction in gene or this corrective action, does constitute an admission or agreement by this facility of th facts alleged or conclusions of forth in this statement of deficiencies. The plan of correction and specific correct actions are prepared and/or executed in compliance with of and federal laws. This plan of correction constitutes a writte allegation of substantial compliance with Federal Med and Medicaid requirements.	and/or execution of correction in general, ctive action, does not a admission or by this facility of the dor conclusions set estatement of a The plan of a specific corrective prepared and/or compliance with state laws. This plan of constitutes a written is substantial with Federal Medicare		
K 0000								
Bldg. 01	Licensure Survey w	00020 55059	K 0	000	DISCLAIMER STATEMENT: Preparation and/or execution this plan of correction in gene or this corrective action, does constitute an admission or agreement by this facility of th facts alleged or conclusions s forth in this statement of deficiencies. The plan of correction and specific correct	eral, not ne set		

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

At this Life Safety Code survey, The Waters of

Huntington Skilled Nursing Facility was found not

in compliance with Requirements for Participation

TITLE (X6) DATE

executed in compliance with state

and federal laws. This plan of

correction constitutes a written

Bryce Tomasi Administrator 07/15/2024

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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PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155059	A. BUILDING B. WING	01	COMPLETED 07/01/2024
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	1500 G	ADDRESS, CITY, STATE, ZIP COD GRANT ST NGTON, IN 46750	
(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)	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation of the Care Occupation of th	cility has a fire alarm system n in the corridors, areas open battery powered smoke dent sleeping rooms. The ty of 85 and had a census of s survey. residents have customary ered. All areas providing te sprinklered.		allegation of substantial compliance with Federal Medi and Medicaid requirements.	care
K 0222 SS=F Bldg. 01	be equipped with a requires the use of egress side unless special locking arraction. CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one loc permitted on each be made for the raby: remote control locks or keys carries.	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: OR SECURITY THREAT wing arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the			

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Event ID:

EY1321

Facility ID: 000020

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155059	B. W	NG		07/01	/2024
				CED FEET	ADDRESS OF A STATE OF COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(ALCKULED NUDCING FACILITY			RANT ST		
WATERS	OF HUNTINGTOR	N SKILLED NURSING FACILITY, 1	ΠE	HUNTII	NGTON, IN 46750		
(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
	18.2.2.2.5.1, 18.2	.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of						
	the Clinical or Sec	curity Locking requirements					
	are being met. In	addition, the locks must be					
	electrical locks that	at fail safely so as to					
	release upon loss	of power to the device; the					
	building is protect	ed by a supervised					
	automatic sprinkle	er system and the locked					
	space is protected	d by a complete smoke					
	detection system	(or is constantly monitored					
	at an attended loo	cation within the locked					
	space); and both	the sprinkler and detection					
	systems are arrar	nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
		delayed-egress locking					
		in accordance with					
		permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
	-	or an approved, supervised					
	automatic sprinkle	-					
	18.2.2.2.4, 19.2.2						
		ROLLED EGRESS					
	LOCKING ARRAI						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2						
		BY EXIT ACCESS					
	LOCKING ARRAI						
	_	it access door locking in					
	accordance with 7	7.2.1.6.3 shall be permitted	1				

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Event ID:

EY1321

Facility ID: 000020

If con

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155059	B. WI			07/01	/2024
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
		N SKILLED NURSING FACILITY, T	HE		RANT ST NGTON, IN 46750		
		·	L		TOTOIN, IIN 40730		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
TAG		es in buildings protected		TAG			DATE
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.	э					
	18.2.2.2.4, 19.2.2	.2.4					
	Based on observation	on and interview, the facility	K 02	222			07/30/2024
		f over 5 exterior exit doors were			CORRECTIVE ACTIONS		
	-	nd able to open on first try.			TAKEN: On 7/30/2024 the		
	_	ice could affect all occupants			Maintenance Supervisor/desig	•	
	in the facility.				repaired the doors at exit #9,	6 &	
					11 to ensure they are readily		
	Findings include:				accessible and able to open o		
	Dagad on abase	one and interviewe during a			first try to meet set standards.		
		ons and interviews during a with the Administrator and			The Administrator verified the		
		visor (MS) on 07/01/24			on 7/30/ ALL OTHERS W POTENTIAL TO BE AFFECT		
	_	and 1:30 p.m., the following exit			On 7/30/2024 the Maintenance		
		essive force and pressure to			Supervisor/designee inspecte		
	-	te time of survey, Exit #9, Exit			doors and found no other neg		
	-	he MS stated that the			findings. MEASURES TO		
	aforementioned doc	ors had been an issue due to			PREVENT REOCCURRENCE	E: On	
	decay and weather	and were in need of being			7/15/2024 the Administrator th		
	replaced. Door # 6	was able to open after several			Maintenance Supervisor/desig	gnee/	
		cking the door. After several			all staff to ensure exterior doo	rs	
		ole effort exit doors #9 and #6			are readily accessible and abl	e to	
	were also eventuall	y opened.			open on first try to meet set		
		1 11 11 4			standards. Maintenance		
	This finding was ac				Supervisor/designee will ensu	re	
		Maintenance Supervisor at the			exterior doors are readily	. n	
	ume of discovery a	nd again at the exit conference.			accessible and able to open of first try as a part of the facility		
	3.1-19(b)				Weekly Preventive Maintenan		
	5.1 17(0)				Program and document those		
					inspection results as appropri		
					If any issues are discovered, t		
					will be addressed and resolve	-	
					immediately. The Maintenand		
					Supervisor/designee will revie		
					with the Administrator the		

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Event ID:

EY1321

Facility ID: 000020

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	OF CORRECTION	IDENTIFICATION NUMBER 155059	A. BUILDING B. WING	01	COMPLETED 07/01/2024
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	1500 G	ADDRESS, CITY, STATE, ZIP COD FRANT ST NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				inspection results. MONITORING CORRECTIVE ACTION: 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 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. The plan of correction constitutes credible allegation of complian with all regulatory requirement Our date of compliance is 7/30/2024.	hly ce g. by n as is our nce
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			

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Event ID:

EY1321

Facility ID: 000020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	01	COMPLETED		
		155059	B. W	ING			/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIEF	ξ			RANT ST			
WATERS	OF HUNTINGTON	N SKILLED NURSING FACILITY, T	THE_	HE HUNTINGTON, IN 46750				
(X4) ID		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	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	the door.							
		and zone locations of						
	REMARKS.	that are deficient in						
	19.3.2.1, 19.3.5.9							
	19.5.2.1, 19.5.5.9							
	Area	Automatic Sprinkler						
	Separation	N/A						
	a. Boiler and Fuel	-Fired Heater Rooms						
	b. Laundries (larg	er than 100 square feet)						
	c. Repair, Mainter	nance, and Paint Shops						
	d. Soiled Linen Ro	ooms (exceeding 64						
	gallons)							
	e. Trash Collectio							
	(exceeding 64 gal	•						
		orage Rooms/Spaces						
	(over 50 square fe	•						
		classified as Severe						
	Hazard - see K32	•					0-11-12-2	
		on and interview, the facility	K 0	321	p paraid="1985506081"	0.4.4	07/17/2024	
		f over 10 hazardous area doors,			paraeid="{33482fe6-f90e-47fe	9-914c		
		ms, were provided with elf-closing devices. This			-d4feb9548556}{129}" >			
		ould affect more than 5 staff						
	and visitors.	outd affect more than 5 starr			CORRECTIVE ACTIONS			
	and visitors.				TAKEN:			
	Findings include:				77112111			
	-							
		ons and interviews during a			·On 7/17/2024 the Maintena	nce		
	•	with the Administrator and			Supervisor/designee installed			
	-	visor (MS) on 07/01/24			self-closing device on corridor			
		and 1:30 p.m., the following			to the storage room near the f			
	was noted:				lobby to meet set standards.			
	A) mt 110: 75				Administrator verified the work	k on		
		oom" near the front lobby,			7/17/2024.			
	greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor doors (the room had two doors leading into the corridor,							
				On 7/45/2004 the NAS' 1				
				On 7/15/2024 the Maintena				
		et apart) to this room were not			Supervisor/designee installed self-closing device on corridor			
	approximately offer	aparty to and room were not	1		I sour-closing device on coman	uoui	1	

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Event ID:

EY1321

Facility ID: 000020

If continuation sheet

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PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

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
		155059	B. W	ING		07/01/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			RANT ST		
WATERS	S OF HUNTINGTO	N SKILLED NURSING FACILITY, 1	ГНЕ		NGTON, IN 46750		
(X4) ID	SUMMARY	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 APPROPRIA	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	equipped with a sel	lf-closing device.			to the housekeeping storage/o		
					office area to meet set standa		
		ping Storage / Old Office Area,			The Administrator verified the	work	
	greater than 50 square feet, had at least 17 cardboard boxes stored inside the room. The				on 7/15/2024.		
		s room was not equipped with			ALL OTHERO WITH		
	a self-closing devic	ce or self-closing hinges.			·ALL OTHERS WITH	CD.	
	This finding was a	cknowledged by the			POTENTIAL TO BE AFFECT	ΞD:	
	_	Maintenance Supervisor at the					
		and again at the exit conference.			ol class="NumberListStyle2		
	diffic of discovery a	and again at the exit conference.			SCXW115940436 BCX8"		
	3.1-19(b)				role="list" start="1"		
	3.1-19(0)				style="-webkit-user-drag: non-	٥.	
					-webkit-tap-highlight-color:	٥,	
					transparent; margin: 0px; pad	dina:	
					Opx; user-select: text; cursor:	anig.	
					text; list-style-type: lower-alph	a·	
					overflow: visible;"	ч,	
					MEASURES TO PREVENT		
					REOCCURRENCE:		
					On 7/12/2024 the Administ	rator	
					in serviced the Maintenance	alUi	
					Supervisor/designee on the		
					requirement to ensure that all		
					hazardous area doors are pro	vided	
					with a self-closing device to m		
					set standards.		
					·Maintenance		
					Supervisor/designee will ensu	re	
					that all hazardous area doors		
					provided with a self-closing de		
					as a part of the facility's month		
					Preventive Maintenance Prog	-	
					and document those inspection		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/23/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155059	B. V	/ING	07/01/	2024	
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED		LOWEL ED NUIDOINO EAGULITY	T		RANT ST		
WATERS	S OF HUNTINGTON	SKILLED NURSING FACILITY,	THE	HUNIII	NGTON, IN 46750		
(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 APPROPRIAT DEFICIENCY)	ΤF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					results as appropriate. If any		
					issues are discovered, they wi	ll be	
					addressed and resolved		
					immediately. The Maintenance	е	
					Supervisor/designee will review	N	
					with the Administrator the		
					inspection results.		
					·The Administrator will monit	or	
					adherence to the Preventative		
					Maintenance schedule and		
					validate the Preventative		
					Maintenance is in place.		
					·MONITORING CORRECTIV	∕E	
					ACTION:		
					·The inspection results will b		
					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 by	ру	
					the QA/PI Committee with		
					subsequent plans of correction	า	
					developed and implemented a	s	
					deemed necessary to ensure		
					compliance is maintained.		
	I		1				

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Event ID:

EY1321

Facility ID: 000020

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This plan of correction constitutes

our credible allegation of compliance with all regulatory

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155059	B. WI			07/01/		
					_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
\\\\\			–		RANT ST			
WATERS	OF HUNTINGTON	I SKILLED NURSING FACILITY, T	HE	HUNIII	NGTON, IN 46750			
(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	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE	
					requirements. Our date of			
					compliance is 7/17/2024.			
					·			
K 0324	NFPA 101							
SS=E	Cooking Facilities							
Bldg. 01	Cooking Facilities							
	Cooking equipmen	•						
		IFPA 96, Standard for						
		I and Fire Protection of						
		ing Operations, unless:						
		ng equipment (i.e., small						
		s microwaves, hot plates,						
	,	for food warming or limited						
	_	ance with 18.3.2.5.2,						
	19.3.2.5.2							
	_	open to the corridor in						
	•	ents with 30 or fewer						
		ith the conditions under						
	18.3.2.5.3, 19.3.2.							
		in smoke compartments						
		atients comply with						
		18.3.2.5.4, 19.3.2.5.4.						
		protected according to						
	•	3 are not required to be rdous areas, but shall not						
	be open to the cor							
		18.3.2.5.4, 19.3.2.5.1						
	through 19.3.2.5.5							
	•	on and interview, the facility	K 03	224	K324– It is the intent of the fac	cility	07/17/2024	
		kitchen range hood system in	IX U.) / T	to ensure to install the kitchen	-	07/17/2024	
		requirements of LSC 9.2.3.			range hood system in accorda			
		commercial cooking			with the requirements of LSC			
		installed in accordance with			to meet set standards.			
		for Ventilation Control and			1. CORRECTIVE ACTIONS			
	·	Commercial Cooking			TAKEN:			
		96, 2011 edition, Section 6.2.4.1						
	_	hood system filters shall be			a. /17/2024 the			
	_	p tray beneath their lower			Administrator/designee placed	2 t		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155059	B. W	ING		07/01/	2024
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
			I		T		975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ll be kept to the minimum size		ING	additional drip trays to the kitc	hen	DATE
	-	rease and shall be pitched to			range hood system to meet se		
	_	ed metal container having a			standards. The Administrator		
		ling 1 gal (3.785 L). This			verified the work on		
	deficient practice could affect up to 6 staff in the kitchen area.				7/17/2024.		
					2. ALL OTHERS WITH		
	Findings include:				POTENTIAL TO BE AFFECTE	ED:	
		ons and interviews during a			a residents and all staff and		
	,	vith the Administrator and			visitors have the potential to b	е	
	_	visor (MS) on 07/01/24			affected but none were.		
		and 1:30 p.m., the design of the					
	*	es four drip trays, two on each			3. MEASURES TO PREVENT	-	
		t side contained a (1) drip tray,			REOCCURRENCE:		
		sing the metal drip trays					
		hen range hood system. The			a. On 7/15/2024 the		
		ot previously noticed that the			Administrator the Maintenance		
	hood system was m	issing 3 of the 4 drip trays.			Supervisor/Dietary Manager a		
	TEL: C: 1:	1 1 1 11 4			all dietary staff on the requirer		
	This finding was ac				to ensure the kitchen range ho		
		Maintenance Supervisor at the			system has all 4 metal drip tra	-	
	ume of discovery at	nd again at the exit conference.			installed to meet set standards	5.	
	3.1-19(b)				b. Maintenance Supervisor/Di	etarv	
					Manager will ensure the kitche		
					range hood system has all 4 n		
					drip trays installed as a part of		
					facility's monthly Preventive		
					Maintenance Program and		
					document those inspection res	sults	
					as appropriate. If any issues	are	
					discovered, they will be addre	ssed	
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra	tor	
					the inspection results.		
					c Administrator will monitor		
					adherence to the Preventative	,	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	A. B	MULTIPLE CO UILDING /ING	onstruction 01	(X3) DATE COMPI 07/01	LETED
	PROVIDER OR SUPPLIER	I SKILLED NURSING FACILITY,	THE	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					Maintenance schedule and validate the Preventative Maintenance is in place. 4. MONITORING CORRECT	IVE	
					ACTION: a. The monitoring results will	be	
					presented by the Administrate the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/17/2024.	g. n by on as	
K 0346 SS=F Bldg. 01	services for more period, the author be notified, and the evacuated or an a provided for all pa	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/01/2024		
	ROVIDER OR SUPPLIER	I SKILLED NURSING FACILITY, T	HE	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Based on record rev failed to provide a c protection of all res to be followed in th	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION riew and interview, the facility omplete written policy for the idents indicating procedures e event the fire alarm system of service for four hours or	K 0	ID PREFIX TAG 346	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) K346— It is the intent of the factor ensure to provide a complete written policy for the protection all residents indicating proceduto be followed in the event the	cility te n of ures	(X5) COMPLETION DATE 07/08/2024
	with LSC, Section 9 affects all occupants	ur hour period in accordance 0.6.1.6. This deficient practice s.			alarm system has to be placed out of service for four hours or more in a twenty four hour per in accordance with LSC, Secti	iod	
	Administrator and I	view and interview with the Maintenance Supervisor (MS) n 9:15 a.m. and 11:30 a.m., the			9.6.1.6 to meet set standards. CORRECTIVE ACTIONS TAK On 7/8/2024 the	ŒN:	
	Indiana State Depar Gateway link at http primary method or	and to include contacting the timent of Health via the ISDH os://gateway.isdh.in.gov as the boy the secondary method when is nonoperational by			Administrator/Maintenance Supervisor updated the fire wa plan to include contacting the Indiana State Department of Health via the Gateway link at		
	e-mailing it to incid interview during the Administrator acknowledge	dent Reporting form and ents@isdh.in.gov. Based on erecord review, the owledged the fire watch eided stated to contact the			https://gateway.isdh.in.gov as primary method or by the secondary method when the IS gateway is nonoperational by completing the Incident Repor	SDH	
	Indiana State Depar	tment of Health without a not via the ISDH Gateway link ress listed above.			form and emailing it to incidents@isdh.in.gov meet se standards. The Administrator verified the work on 7/8/2024.		
	Administrator and I time of discovery w	Maintenance Supervisor at the hen a copy of the incomplete a to the surveyor, and again at			·ALL OTHERS WITH POTENTIAL TO BE AFFECTE	ED:	
	3.1-19(b)				MEAGURES TO RREVENT		
					·MEASURES TO PREVENT REOCCURRENCE:		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	,		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155059	A. BU B. WI	JILDING NG	01	COMPL 07/01/	
		100000	D. WI			07/01/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD RANT ST		
WATERS	OF HUNTINGTON	I SKILLED NURSING FACILITY, TI	HE		NGTON, IN 46750		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	ALGOLING I ON				·On 7/8/2024 the Administral in serviced the Maintenance Supervisor/DON/designee on requirement to ensure the fire watch plan includes contacting Indiana State Department of Health via the ISDH gateway I or by secondary method when gateway link is nonoperational emailing to incidents@isdh.in.got omeet set standards. ·Maintenance Supervisor/DON/designee will ensure the fire watch plan inclucontacting the Indiana State Department of Health via the I gateway link or by secondary method when the gateway link nonoperational by emailing to incidents@isdh.in.gov as a pathe facility's monthly Preventiv Maintenance Program and document those inspection resas appropriate. If any issues discovered, they will be addresand resolved immediately. The Maintenance Supervisor/desigwill review with the Administration the inspection results. ·The Administrator will monitadherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place.	the g the ink the by gov udes SDH is rt of e sults are essed e unee tor	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIE	R N SKILLED NURSING FACILITY	, THE	1500 G	ADDRESS, CITY, STATE, ZIP COD FRANT ST NGTON, IN 46750		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					·MONITORING CORRECT ACTION:	IVE	
					The inspection results will in presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month 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.	e hlly ice g. by on	
					This plan of correction constit our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/8/2024.		
K 0354 SS=F Bldg. 01	extent and duration been determined are inspected and recommendations management or commended.						

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A. BUILDING 01 B. WING	COMPLETED 07/01/2024
STREET ADDRESS, CITY, STA 1500 GRANT ST HUNTINGTON, IN 4675	
PREFIX (EACH CORRECTIV CROSS-REFERENC	PLAN OF CORRECTION VE ACTION SHOULD BE JED TO THE APPROPRIATE FICIENCY) (X5) COMPLETION DATE
is the intent of ensure to provous policies for the residents in the automatic spring placed out of some or more in a powith LSC, Sectiset standards. ACTIONS TAMA Administrator/I Supervisor upoplan to include Indiana State I Health via the at <a href="https://gatewthe-primary messecondary messecondary</td><td>#442ff-76db-4725-ab5 #39e}{111}">K354— It #the facility to #ide correct written #e protection of all #e event the #nkler system be #service for 10 hours #eriod in accordance #tion 9.7.5 to meet #CORRECTIVE #KEN: On7/8/2024 the #Maintenance #dated the fire watch #e contacting the #Department of #ISDH Gateway link #way.isdh.in.gov as #ethod or by the #thod when the ISDH #noperational by #e Incident Reporting #iling it to #h.in.gov meet set #ne Administrator #ork on #ALL OTHERS #ITIAL TO BE	
	STREET ADDRESS, CITY, ST 1500 GRANT ST HUNTINGTON, IN 467 ID PREFIX TAG PROVIDERS (EACH CORRECT) CROSS-REFERENCE DE TO PROVIDERS (EACH CORRECT) CROSS-REFERENCE TO PROVIDERS (EACH

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	primary method or the ISDH Gateway completing the Incidending it to incide interview during the Administrator acknowledge documentation proving Indiana State Depart phone number, and or at the e-mail add. This finding was ac Administrator and Matime of discovery was according to the ISDH Gateway and Indiana State Depart phone number, and Indiana State Depart phone number of the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana State Depart phone number of discovery was according to the ISDH Gateway and Indiana	by the secondary method when is nonoperational by dent Reporting form and ents@isdh.in.gov. Based on e record review, the owledged the fire watch yided stated to contact the timent of Health without a not via the ISDH Gateway link ress listed above.			MEASURES TO PREVENT REOCCURRENCE: On 7/8/2 the Administrator in serviced Maintenance Supervisor/desi on the requirement to ensure fire watch plan includes conta the Indiana State Departmen Health via the ISDH gateway or by secondary method whe gateway link is nonoperationa emailing to incidents@isdh.in to meet set standards. Maintenance Supervisor/designee will ensu the fire watch plan includes contacting the Indiana State Department of Health via the gateway link or by secondary method when the gateway lin nonoperational by emailing to incidents@isdh.in.gov as a pi the facility's monthly Preventi Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. T Maintenance Supervisor/desi will review with the Administra the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance is in place. MONITORING CORRECTIVE ACTION: The inspection results will be presented by the Maintenance Supervisor/designee to the	the gnee the acting to of link in the all by a government of the sesults are essed to the gnee attoring the action of the gnee attoring th	

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	OF CORRECTION	IDENTIFICATION NUMBER 155059	A. BUILDING B. WING	01	COMPLETED 07/01/2024
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combusting is not except to the covering to the	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or rials have positive latching atches are prohibited by hese requirements do not		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 the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes of credible allegation of compliant with all regulatory requirement Our date of compliance is 7/8/2024.	nly ce

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	1500 GI	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lat other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrit resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc. Based on observation failed to ensure 4 of impediment to closificate and would residents. Findings include: Based on observation tour of the facility with Maintenance Super between 11:30 a.m. corridor doors failed respective door frame a) The "Miscellane East Hall - equipped	fire window assemblies are a sprinklered compartments octions in area or fire is or frames in window. Parts 403, 418, 460, 482, 483 as a sings, automatics closing on and interview, the facility of over 30 corridor doors had no ong and latching into the door sist the passage of smoke. The passage of smoke ice could affect 6 staff and 6 and interviews during a with the Administrator and wisor (MS) on 07/01/24 and 1:30 p.m., the following do to latch positively into their nessembles out the self-closing device. The passage of smoke in the did with a self-closing device. The passage of the did with a self-closing device. The passage of the did with a self-closing device. The passage of the	K 0	363	p paraid="1042071753" paraeid="{305442ff-76db-472:3-a0253057739e}{245}" > CORRECTIVE ACTIONS TAR On 7/15/2024 the Maintena Supervisor/designee made re to corridor door Miscellaneous Storage Room on the East Haensure it latches positively interest door frame to meet set standa The Administrator verified the repairs on 7/15/2024.	KEN: Ince pairs s all to o the ards.	07/15/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2024		
	PROVIDER OR SUPPLIEI	R N SKILLED NURSING FACILITY, T	ГНЕ	1500 G	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Administrator and				Supervisor/designee made re to corridor door Therapy Equipment Room to ensure it latches positively into the doo frame to meet set standards. Administrator verified the repart on 7/15/	The	
					On 7/15/2024the Maintenar Supervisor/designee made re to corridor door Resident roon to ensure it latches positively the door frame to meet set standards. The Administrator verified the repairs on 7/15/	pairs n 306 into	
					On 7/15/2024 the Maintena Supervisor/designee made re to corridor door Resident Roo 310 to ensure it latches positivinto the door frame to meet se standards. The Administrator verified the repairs on 7/15/2024.	pairs m /ely :t	
					·ALL OTHERS WITH POTENTIAL TO BE AFFECTI	ED:	
					The Maintenance Supervisor/designee inspecte doors and found no other neg findings.		
					·MEASURES TO PREVENT	-	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA X2) MULTIPLE CONSTRUCTION X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155059	B. WI	ING		07/01/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				RANT ST		
WATERS	OF HUNTINGTON	I SKILLED NURSING FACILITY, TI	HE ·	HUNTIN	NGTON, IN 46750		
(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 APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	·On 7/15/2024 the Administral in serviced the Maintenance Supervisor/and all other staff members on the requirement in provide corridor doors that wo close completely and latch positively into the frame to me set standards. ·Maintenance Supervisor/designee will inspecial doors throughout the facility monthly to ensure corridor door latch positively into the frame part of the facility's Preventive Maintenance Program and document those inspection resus as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/designed will review with the Administration the inspection results.	to uld et ect y ors as a sults are ssed ae gnee	DATE
					SCXW158631361 BCX8" role="list" start="3"		
					style="-webkit-user-drag: none	∋;	
					-webkit-tap-highlight-color:	alia a	
					transparent; margin: 0px; pado 0px; user-select: text; cursor:	aing:	
					text; list-style-type: lower-alpha	a:	
					overflow: visible;"	∽ ,	
					The Administrator will monitor		
					adherence to the Preventative		
					Maintenance schedule and		

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i '			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155059	A. BU B. W.	JILDING ING	01	COMPLETED 07/01/2024	
		100008	Б. W.	_		07/01/2024	
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF HUNTINGTON	I SKILLED NURSING FACILITY, T	1500 GRANT ST THE HUNTINGTON, IN 46750				
(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 DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	validate the Preventative Maintenance is in place. MONITORING CORRECTIVE ACTION: 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 month Quality Assurance/Performance Improvement (QA/PI) meeting	nly ce	
					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.	n l	
					This plan of correction constitution of compliance with all regulatory requirements. Our date of compliance is 7/15/2024.		
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke ba	Iding Spaces - Smoke Iding Spaces - Smoke arriers are 1-3/4-inch thick d-core doors or of esists fire for 20 minutes.					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	(X2) MULTIPLE CO A. BUILDING B. WING		onstruction 01	(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	1500 GI	ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of provides a minimulation for swinging or ho 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 1 of would restrict the mr 20 minutes. LSC 19 barriers shall comple 8.5.4.1 requires door the opening leaving necessary for proper practice could affect Findings include: Based on observation tour of the facility	on and interview, the facility of 5 sets of smoke barrier doors hovement of smoke for at least 9.3.7.8 requires doors in smoke by with LSC Section 8.5.4. LSC ors in smoke barrier shall close only the minimum clearance or operation. This deficient of t17 residents and staff. Ons and interviews during a with the Administrator and wisor (MS) on 07/01/24 and 1:30 p.m., the set of smoke of the memory care unit did not did latch. The MS worked on hism during the survey and hare the door set did not latch.	K 0	374	CORRECTIVE ACTIONS TAKE On 7/8/2024 the Maintenar Supervisor/designee made re to the smoke barrier doors with the memory care unit to ensure they close completely and late meet set standards. The Administrator verified the repart on 7/8/ ALL OTHERS WITH POTENTIAL TO BE AFFECTIVE On 7/8/2024 the Maintenar Supervisor/designee inspecte smoke barrier doors throughout the facility and found no other negative findings. MEASURES TO PREVENT REOCCURRENCE: On 7/8/2024 the Administration serviced the Maintenance	nce pairs thin re ch to airs ED: ance d all ut	07/08/2024

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG <u>01</u>	(X3) DATE SU COMPLET 07/01/20	ED
	ROVIDER OR SUPPLIER	R N SKILLED NURSING FACILITY,	15	REET ADDRESS, CITY, STATE, ZIP CO 00 GRANT ST JNTINGTON, IN 46750	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A G DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE
				Supervisor/designee are the requirement that so doors must close complatch to meet set stands	noke barrier letely and	
				·Supervisor/designed all smoke barrier doors the facility monthly to e close completely and lapart of the facility's Pre Maintenance Program document those inspect as appropriate. If any discovered, they will be and resolved immediate Maintenance Supervisor will review with the Adrithe inspection results.	throughout nsure they atch as a ventive and ction results issues are addressed ely. The or/designee	
				The Administrator with adherence to the Preventance schedule validate the Preventative Maintenance is in place	entative and /e	
				·MONITORING COR ACTION: ·The inspection resul presented by the Maint Supervisor/designee to Administrator monthly a Administrator will prese inspection results at the Quality Assurance/Perf Improvement (QA/PI) n	ts will be enance the and the ent the e monthly formance	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059	ì	JILDING	onstruction 01	(X3) DATE COMPL 07/01/	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGTON SKILLED NURSING FACILITY, T				STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HUNTINGTON, IN 46750				
(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	
					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.	1		
					This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/8/2024.	tes		

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