STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. BUILDING -- B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/10/24 Facility Number: 000519 Provider Number: 155571 AIM Number: 100287230 At this Emergency Preparedness survey, The Waters of Dunkirk 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 46 and had a census of 35 at the time of this survey. Quality Review completed on 06/11/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/10/24 Facility Number: 000519 Provider Number: 155571 AIM Number: 100287230 At this Life Safety Code survey, The Waters of Dunkirk Skilled Nursing Facility was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyisha Wheeler	Administrator	06/27/2024

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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	155571	A. BUILDING 01 B. WING	06/10/2024

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery-operated smoke detectors in the resident rooms. The facility has a capacity of 46 and had a census of 35 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/11/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	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 Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	155571	A. BUILDING 01 B. WING	06/10/2024

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 5 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 8 residents. Findings include: Based on observations and interview with the Maintenance Director (MD) and Administrator on 06/10/24 between 12:30 p.m. and 2:15 p.m., the exit door #6 was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit doors was not posted by the access control pad. The findings were reviewed with the MD at the time of discovery and again with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	**K222**– It is the intent of the facility to ensure the means of egress through exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 6/10/24 the Maintenance Supervisor/designee posted how to obtain the code to release the door at exit door #6 to meet set standards. The Administrator verified the work on 6/10/24 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 6/10/24 the Maintenance Supervisor/designee inspected all doors and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 6/10/24 the Administrator inserviced the Maintenance Supervisor/designee/ all staff to ensure how to obtain the code is posted at exit doors to meet set standards. b Maintenance Supervisor/designee will ensure	07/02/2024

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			how to obtain the code is posted at exit doors as a part of the facility's Weekly Preventive Maintenance 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 inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/2/24.**	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the activities area. This deficient practice could affect staff and up to 15 residents' staff and visitors.	K 0321	**K321** - It is the intent of the facility to ensure to maintain protection of hot oil in popcorn popper in the activities area to meet set standards.	06/10/2024

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	Findings include: Based on observations and interview with the Maintenance Director (MD) and Administrator on 06/10/24 between 12:30 p.m. and 2:15 p.m., a hot oil popcorn popper was being stored in the activity area. When asked where the machine was used the MD stated "right here." The aforementioned area had a door with a self-closing device installed but the door did not latch. The findings were reviewed with the MD at the time of discovery and again with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		1 **CORRECTIVE ACTIONS TAKEN**: a On 6/10/24 the Maintenance Supervisor/designee relocated the hot oil popcorn popper to a fire rated hazardous area with a self-closing and latching door ie. Kitchen to meet set standards. The Administrator verified the work on 6/10/24. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 6/10/24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure that all hazardous materials, including the popcorn machine, is stored in a hazardous area that is fire rated and has doors that self-close and latch fully into the frame to meet set standards. b Maintenance Supervisor/designee will ensure that all hazardous materials, including the popcorn machine, is stored in a hazardous area that is fire rated and has doors that self-close and latch fully into the frame as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved	

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			immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/10/24.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

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	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 6 staff and 6 residents. Findings include: Based on observations and interview with the Maintenance Director (MD) and Administrator on 06/10/24 between 12:30 p.m. and 2:15 p.m., the electrical panel near the 200 hall nurses station was unlocked when tested. Based on interview at the time of observation, the MD stated the electrical panel will need to be locked. The findings were reviewed with the MD at the time of discovery and again with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**K511**– It is the intent of the facility to ensure electrical panels in the corridors are secured from non-authorized personnel to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 6/10/24 the Maintenance Supervisor/designee locked the electrical panel near the 200 hall nurses station to meet set standards. The Administrator verified the work on 6/10/24 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 6/11/24 the Maintenance Supervisor/designee inspected all electrical panels throughout the facility to ensure they were locked and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 6/10/24 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical panels must remain locked to meet set standards. b Maintenance Supervisor/designee will inspect all electrical panels monthly to ensure they are locked as a part	06/11/2024

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			of the facility's Preventive Maintenance 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 inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/11/24.**	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strip powering medical equipment met the required UL rating of 1363A or 60601-1. This deficient practice affects one resident in room 215. Findings include: Based on observations and interview with the Maintenance Director (MD) and Administrator on 06/10/24 between 12:30 p.m. and 2:15 p.m., an oxygen concentrator was plugged in to a power	K 0920	**K920** – It is the intent of the facility to ensure flexible cord power strips powering medical equipment meet the required UL rating of 1363A or 60601-1 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 6/10/24 the Maintenance Supervisor/designee removed the power strip in Resident room 215 to meet set	07/02/2024

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	strip in Resident Room #215. Along with the concentrator, other electrical non-medical equipment was plugged into the same aforementioned power strip. The Maintenance Director agreed an oxygen concentrator was plugged in to a power strip along with other non-medical devices. The findings were reviewed with the MD at the time of discovery and again with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		standards. The Administrator verified the removal on 6/10/24. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 6/11/24 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 6/11/24 the Administrator inserviced the Maintenance Supervisor/designee/all other staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection 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 inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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			documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 7/2/24.**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).			

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	155571	A. BUILDING 01 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations and interview with the Maintenance Director (MD) and Administrator on 06/10/24 between 12:30 p.m. and 2:15 p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There were two vents to the outside, but the vents did not contain a working mechanically ventilated exhaust fan. Based on interview at the time of observation, the MD stated the oxygen fan was disconnected because it was wearing out and making noise which the staff complained about. A new fan had not yet been purchased to replace the broken/disconnected fan. The findings were reviewed with the MD at the time of discovery and again with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage room where oxygen transferring takes place, is provided with properly working medical ventilation to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 6/11/24 the Maintenance Supervisor installed the exhaust fan in the oxygen storage/transfer room to meet set standards. The Administrator verified the work on 6/11/24 . 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 6/10/24 the Administrator inserviced the Maintenance Supervisor/designee to ensure the ventilated exhaust fan is operating in the oxygen storage/transfer room to meet set standards. 1.Maintenance Supervisor/designee will ensure the ventilated exhaust fan is operating in the oxygen storage/transfer room as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The	06/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. BUILDING 01 B. WING	06/10/2024

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			Maintenance Supervisor/designee will review with the Administrator the inspection results. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the DON/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/11/24.**	