STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155617	A. BUILDING -- B. WING	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

(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: 02/07/25 Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090 At this Emergency Preparedness survey, Waters of Chesterfield 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 60 and had a census of 43 at the time of this survey. Quality Review completed on 02/11/25	E 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0000 Bldg. 01	A 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: 02/07/25 Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090 At this Life Safety survey, Waters of Chesterfield Skilled Nursing Facility was found not in compliance with Requirements for Participation in	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eileen R Thomas HFA	Administrator	02/21/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 sleeping rooms. The facility has a capacity of 60 and had a census of 43 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 02/11/25		**of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of 1 rooms greater than 50 square feet and being used for storage of large amounts of combustibles was protected as a hazardous area. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Administrator on 02/07/25 at 11:15 a.m., the schedulers office contained 30 boxes of combustibles supplies, was greater than 50 square feet, therefore making the room a hazardous area. The room was not protected as a hazardous area because the corridor door to the room was not self-closing or	K 0321	**K321**– It is the intent of the facility to ensure rooms greater than 50 square feet and being used for storage of large amounts of combustibles are protected as a hazardous area to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 2.14.2025 the Maintenance Supervisor/designee installed a self-closer to the door to the schedulers office to meet set standards. The Administrator verified the work. **2 ALL OTHERS WITH**	02/28/2025

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	automatic closing. Based on an interview at the time of observation, the Administrator agreed the schedulers office contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**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 2.17.2025 the Administrator inserviced the Maintenance Supervisor/ designee to ensure rooms greater than 50 square feet and being used for storage of large combustibles are protected as a hazardous area to meet set standards. b Maintenance Supervisor/designee will ensure rooms greater than 50 square feet and being used for storage of large combustibles are protected as a hazardous area 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 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	

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			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.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas were provided with metal or noncombustible containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect staff in the smoking area Findings include: Based on observations with the Administrator on 01/07/25 at 12:25 p.m., in the staff smoking area there was a smoker's pole that was tipped over with the lid off. Also, there was a metal bucket containing cigarette buts with no cover. Based on an interview at the time of observations, the Administrator agreed the smoker's pole was tipped over with the lid off and there was a metal bucket containing cigarette butts with no cover. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0741	**K741** – It is the intent of the facility to ensure smoking areas are provided with metal or non-combustible containers with self-closing cover to dispose of cigarette butts to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 2.14.2025 the Housekeeping Supervisor/ Maintenance Supervisor placed the smoker's pole upright and secured it and removed the metal bucket and placed a fire rated metal cigarette butt can with self-closing lid to meet set standards. The Administrator verified the work. 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.	02/28/2025

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			3 **MEASURES TO PREVENT REOCCURRENCE**: a On 2.17.2025 the Administrator inserviced the Maintenance Supervisor/designee/all staff to ensure smoking areas are provided with metal or non-combustible containers to meet set standards. b Maintenance Supervisor/Administrator/DON/Housekeeping Supervisor/designee will conduct weekly inspections on the property to ensure smoking areas are provided with metal or non-combustible containers as a part of the facilities preventative maintenance program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Smoking Policy and validate the 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.	

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			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.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 1 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observations with the Administrator on 02/07/25 at 12:05 p.m., the oxygen storage/transfer room contained four liquid oxygen tanks completely filling the room. This condition does	K 0927	**K927**– It is the intent of the facility to ensure transfilling of oxygen took place in oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 2.17.2025 the DON/Maintenance Supervisor rearranged some of the liquid oxygen tanks from the oxygen storage/transfilling room to ensure a person transfilling oxygen has enough room to transfill while the door is shut to meet set standards. The Administrator verified the work.. 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**:	02/28/2025

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	not leave enough room for a person transfilling oxygen inside the room with the door closed. Based on interview at the time of observation, the Administrator stated staff can not fit inside the room and staff probably are not transfilling in the room with the door closed. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		1.On 2.17.2025 the Administrator inserviced the DON/and all nursing staff/Maintenance Supervisor on the requirement to ensure the oxygen storage/transfilling room has enough room for a person transfilling oxygen to meet set standards. 2.Maintenance Supervisor/DON will ensure the oxygen storage/transfilling room has enough room for a person transfilling oxygen as a part of the facility's Oxygen Policy and Procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/DON/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.	