CENTERS FUI	C MEDICARE & MEDIC				ONID NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG <u></u>	COMPLETED
		155274	B. WING		06/17/2025
			CORD	DEET ADDRESS CITY OF ATE TIN COR	
NAME OF I	PROVIDER OR SUPPLIEF	3		REET ADDRESS, CITY, STATE, ZIP COD	
\A/A TED		NULLED MUDOING EAGULEY T		5 W WASHINGTON ST	
VVATERS	OF ROCKPORTS	SKILLED NURSING FACILITY, T	RC	OCKPORT, IN 47635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF		E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	G DEFICIENCY)	DATE
E 0000					
Bldg					
	An Emergency Pre	paredness Survey was	E 0000	Preparation and/or executio	n of
	conducted by the Ir	ndiana Department of Health in		this plan of correction in ger	ıeral,
	accordance with 42	CFR 483.73.		or this corrective action does	
				constitute an admission or	
	Survey Date: 06/17	7/25		agreement by this facility of	the
Facility Number: 00				facts alleged or conclusions	
		000174		forth in this statement of	
	Provider Number:			deficiencies. The plan of	
	AIM Number: 100	274810		correction and specific corre	ective
				actions are prepared and/or	
	At this Emergency	Preparedness survey, The		executed in compliance with	
		t Skilled Nursing Facility was		and federal laws. This plan	
	_	iance with Emergency		correction constitutes a writt	
	_	irements for Medicare and		allegation of substantial	
		ting Providers and Suppliers, 42		compliance with federal Med	dicare
	CFR 483.73			and Medicaid requirements.	
	0110 100170			and Modicald roddinomonic.	
	The facility has 60	certified beds. At the time of			
	the survey, the cens				
	Ouality Review con	npleted on 06/24/25			
	The requirement at	42 CFR, Subpart 483.73 is NOT			
	MET as evidenced	-			
E 0041	482.15(e), 483.73	s(e), 485.542(e), 485.62			
SS=F	, ,	LTC Emergency Power			
Bldg	'	<b>3</b> ,			
Ŭ	Based on record rev	view and interview, the facility	E 0041	It is the intent of the facility t	07/10/2025
		t the emergency power system	20011	ensure to implement the	0771072025
	•	and maintenance requirements		emergency power system	
		Care Facilities Code, NFPA		inspection, testing and	
		y Code in accordance with 42		maintenance requirements f	ound
	CFR 483.73(e)(2).	-		in the healthcare facilities co	
	- ( )( )			NFPA 110, and life safety of	
	Based on record	review and interview, the		accordance with 42 CFR 48	
		ercise 1 of 1 emergency		(e) (2) and to ensure to exer	
	l line of the			(5) (2) and to onotic to exci	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE
		. I ELO GOLLELEK KEJ KEJENTATIVE 9 31			. ,
Natalie Wa	alker		HFA		07/04/2025

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.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155274	B. W	ING		06/17/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, TH	Ε		PORT, IN 47635		
	1	· · · · · · · · · · · · · · · · · · ·			T	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	,	to meet the requirements of			emergency generator annually		
	NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter				to ensure emergency generate		
	8.4.2. Section 8.4.2 states diesel generator sets in				provided with an alarm annun		
	service shall be exercised at least once monthly,				in a location readily observed	-	
	for a minimum of 30 minutes, using one of the				operating personnel at a regul work station such as a nurses		
	following methods:				station to meet set standards.		
	(1) Loading that maintains the minimum exhaust				Station to meet set standards.		
	gas temperatures as recommended by the				What corrective action(s) wil	.	
	manufacturer				be accomplished for those	•	
	(2) Under operating temperature conditions and at				residents found to have been	,	
	not less than 30 percent of the EPS (Emergency				affected by the deficient	•	
	Power Supply) nameplate kW rating.				practice?		
	Section 8.4.2.3 states diesel-powered EPS				On 7/2/2025 the maintenance		
	installations that do not meet the requirements of				supervisor/licensed generator		
		ised monthly with the available			contractor/designee completed the		
		Power Supply System) load and			required load testing to meet set		
		innually with supplemental		standards. The administrator			
	loads (Load Bank 7	Test) at not less than 50 percent			verified the work on 7/3/2025.		
	of the EPS namepla	ate kW rating for 30 continuous	On 7/8/2025 the licensed				
	minutes and at not	less than 75 percent of the EPS	generator contractor will move the				
	nameplate kW ratir	ng for 1 continuous hour for a	remote generator annunciator				
		f not less than 1.5 continuous			panel to the east nurses statio	n to	
		nt practice could affect all			meet set standards. The		
	residents, staff, and	visitors.			administrator will verify the wo	rk	
					on 7/8/2025.		
	Findings include:						
	D1					u	
		view on 06/17/25 at 1:15 p.m.			How other residents having to		
		ator and Maintenance Director			potential to be affected by th		
		y load percentage for the erator was documented less			same deficient practice will be identified and what corrective		
						е	
		l of the past 12 months. Based time of record review, the			action(s) will be taken?		
		tor acknowledged the			All residents, staff and visitors have the potential to be affect		
		: load on a monthly basis but			but none were.	<del>c</del> u	
	_	% of the name plate rating			but none were.		
		ionally, the Maintenance			What measures will be put in	ıto	
		lged a load bank test for the			place and what systemic		
		ccurred within the past 12			changes will be made to		
	5011014101 1140 1101 0	minim mo publiz	1		Shanges will be illade to		

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Facility ID: 000174

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	<del></del>	COMPI	LETED	
		155274	B. W	ING		06/17	/2025	
				<del></del>				
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.	0.05.0000000	N			WASHINGTON ST			
WATER	S OF ROCKPORTS	SKILLED NURSING FACILITY, 1	IHE	ROCKI	PORT, IN 47635			
(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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\L	DATE	
	month period. It co	ould not be determined when			ensure that the deficient			
	the most recent load	d bank test for the generator			practice does not recur?			
	was performed.				On 7/2/2025 the administrator	r		
	•				inserviced the maintenance			
	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.				supervisor/all staff/designee of	n the		
					requirement to ensure the			
					generator's monthly load testi	na		
					obtains at least 30% of the na	_		
	2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator				plate rating or load bank testi			
					completed and to ensure the	.5		
	was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care				remote generator annunciator	•		
					panel is at a supervised nurse			
					station to meet set standards.			
					The maintenance	•		
		6.4.1.1.17 requires a remote			supervisor/designee will ensu	re		
		storage battery powered shall			the generator's monthly load			
		rate outside of the generating			testing obtains at least 30% o	f the		
		readily observed by operating			name plate rating or load ban			
		lar work station. The			testing is completed and to er			
		e hard-wired to indicate alarm			the remote generator annunc			
		nergency or auxiliary power			panel is at a supervised nurse			
	source as follows:				station as part of the facility's	,,,		
		al signals shall indicate:			monthly preventative mainten	ance		
		ency or auxiliary power source			program and document those			
	is operating to supp				inspection results as appropri			
		y charger is malfunctioning.			If any issues are discovered,			
		al signals plus a common			will be addressed and resolve	•		
	1 1	arn of an engine-generator			immediately. The maintenance			
	alarm condition sha				supervisor/designee will revie			
	a. Low lubricating				with the administrator the	**		
	b. Low water temp				inspection results.			
	c. Excessive water				mopodion results.			
		the main fuel storage tank			How the corrective action(s)			
		4-hour operating supply.			will be monitored to ensure			
	e. Overcrank (faile				deficient practice will not	u I <del>C</del>		
	f. Overspeed.	a w starty.			-			
		ork station will be unattended			recur, i.e., what quality	<b>+</b>		
					assurance program will be p	ul		
	periodically, an audible and visual derangement				into place?		1	

periodically, an audible and visual derangement signal, appropriately labeled, shall be established

at a continuously monitored location. This

The administrator and

maintenance supervisor/designee

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	LTIPLE CO LDING	ONSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155274	B. WIN		<del></del>	06/17/	
		100274	D. ((1)			00/17/	2020
NAME OF P	ROVIDER OR SUPPLIER	Ł			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		NAME OF A SHADON OF A CHARACTER THE	_		WASHINGTON ST		
WATERS	OF RUCKPURTS	SKILLED NURSING FACILITY, THE	-	RUCKP	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	*	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	LD BE COMPLETION	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		shall activate when any of the			will review the emergency		
		1.17(1) and (2) occur but need			preparedness policy manual a		
		onditions individually. This			make changes as necessary t	0	
	_	ould affect all residents, as well			meet set standards. Those		
	as visitors and staff	in the facility.			reviews will be documented as		
	F' 1' ' 1 1				appropriate. The administrato		
	Findings include:				present the results at the QAP	ı	
	Događan -1	om on 06/17/25 at 1.50			meeting. Results and system		
		on on 06/17/25 at 1:50 p.m.			components will be reviewed to	уу	
	during a tour of the facility with the Administrator and Maintenance Director, the remote generator				the QAPI committee with subsequent plans of correction		
	and Maintenance Director, the remote generator annunciator panel was located at the West				developed and implemented a		
	Nurse's Station which was not currently in				developed and implemented a deemed necessary to ensure	S	
	operation. When asked, the Administrator said				compliance is maintained.		
	the West Nurse's Station is currently closed due				compliance is maintained.		
		here are no residents currently			By what date the systemic		
		nd the nearest Nurse's Station			changes for each deficiency		
		ner side of the facility on the			will be completed?		
		erator annunciator panel would			7/10/2025		
		he East Unit if activated.			771072020		
	This finding was re-	viewed with the Administrator					
	and Maintenance D	irector during the exit					
	conference.						
K 0000							
Bldg. 01							
	_	Recertification and State	K 00	00	Preparation and/or execution of		
	_	as conducted by the Indiana			this plan of correction in gener	-	
	•	th in accordance with 42 CFR			or this corrective action does r	ot	
	483.90(a).				constitute an admission or		
	0 5 00	1/25			agreement by this facility of the		
	Survey Date: 06/17	1/25			facts alleged or conclusions se	et .	
	EUG-NI 1 0	00174			forth in this statement of		
	Facility Number: 0				deficiencies. The plan of		
	Provider Number:				correction and specific correct	ive	
	AIM Number: 1002	2/4810			actions are prepared and/or	4-4-	
	At this I if G-fit	Code survey The Witten of			executed in compliance with s		
	At this Life Safety (	Code survey, The Waters of	1		and federal laws. This plan of		I

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	01	COMPL	ETED	
		155274	B. W	ING		06/17/	/2025	
				_				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					WASHINGTON ST			
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, T	HE	ROCKE	PORT, IN 47635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
		fursing Facility was found not in			correction constitutes a written			
	_	equirements for Participation in			allegation of substantial			
	-	l, 42 CFR Subpart 483.90(a),			compliance with federal Medica	are		
		re and the 2012 edition of the			and Medicaid requirements.	aic		
		ction Association (NFPA) 101,			and Medicald requirements.			
Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.								
Health Care Occupancies and 410 IAC 16.2.								
	This ama stame facil	ity was determined to be of						
	1	truction and was fully						
		cility has a fire alarm system						
		•						
	with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping							
		has a capacity of 60 and had a						
	census of 34 at the	time of this survey.						
	A 11 1 .1							
		residents have customary						
	_	ered and all areas providing						
	1	re sprinklered, except two						
		, a wood framed garage used						
		shop and facility storage, as						
		ned house used for facility						
	storage.							
		1 . 1 . 0 . (0 . (0 .						
	Quality Review cor	mpleted on 06/24/25						
IX 0200	NIEDA 404							
K 0300	NFPA 101							
SS=F	Protection - Other	•						
Bldg. 01	D 1 1	. 1.4 . 4 6 774	77.0	200			05/10/0005	
		view and interview, the facility	K 0	300	It is the intent of the facility to		07/10/2025	
		preventative maintenance for			ensure the preventative			
		smoke alarms in resident			maintenance for all battery			
		ed according to manufacturer's			operated smoke alarms in resi			
	_	ons. NFPA 101 in 4.6.12.3			rooms is conducted according	to		
		safety features obvious to the			manufacturer's published			
		red by the Code, shall be			instructions to meet set			
	maintained. NFPA	72, 29.10 Maintenance and			standards.			

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Tests. Fire-warning equipment shall be maintained and tested in accordance with the

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What corrective action(s) will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	01	COMPLETED	
		155274	B. WIN	G		06/17/2025	;
			<del>'</del>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			WASHINGTON ST		
WATERS	S OF ROCKPORTS	SKILLED NURSING FACILITY, TH			PORT, IN 47635		
VV/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	· · · · · · · · · · · · · · · · · · ·		<u> </u>	1100111	01(1, 11(47000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	<b>IPLETION</b>
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	lished instructions and per the			be accomplished for those		
	_	apter 14. NFPA 72, 14.2.1.1.1			residents found to have beer	า	
	Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's				affected by the deficient		
					practice?		
					On 7/1/2025 the maintenance	<b>I</b>	
	_	ons. This deficient practice			supervisor/designee checked	and	
	could affect all resi	dents.			inspected per manufacturer's		
	F: 1: : 1 1				guidelines, weekly, all the batt	-	
	Findings include:				operated smoke alarms to me	et	
	D 1 1	. 06/17/25 4 12 00			set standards. Administrator		
		view on 06/17/25 at 12:00 p.m.			verified work on 7/2/2025.		
		ator and Maintenance Director				41	
	present, the "Battery Operated Smoke Detectors  Maintenance Log" showed monthly testing of the				How other residents having		
	battery operated sm				potential to be affected by th		
		lished instructions on the back			same deficient practice will be		
	_	alarm stated the alarms require			identified and what correctiv	e	
		sed on interview at 12:00 p.m.,			action(s) will be taken?	·	
		irector stated the smoke alarms			All residents, visitors, and staft have the potential to be affect.		
		and agreed the alarms should			but none were.	eu	
		cording to manufacturer's			but none were.		
	published instruction				What measures will be put ir	nto.	
	paonisiea instruction	SHO.			place and what systemic		
	This finding was re	eviewed with the Administrator			changes will be made to		
	_	Director during the exit			ensure that the deficient		
	conference.	8			practice does not recur?		
					On 7/2/2025 the administrator		
	3.1-19(b)				inserviced the maintenance		
					supervisor/designee on the		
					requirements to ensure all bat	tery	
					operated smoke alarms are	·	
					maintained per manufacturer's	,	
					guidelines and testing is		
					conducted on a weekly basis t	to	
					meet set standards.		
					The maintenance		
					supervisor/designee will ensu	re all	
					battery operated smoke alarm		
					are maintained and testing is		
					conducted weekly per		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155274	B. WI	NG		06/17	/2025
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		N/II	_		WASHINGTON ST		
WATERS	S OF ROCKPORTS	SKILLED NURSING FACILITY, THI	E	ROCKE	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI AM OF CORRECTION		(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)	IE	DATE
					manufacturer's guidelines and	will	
					document the results on the		
					battery operated smoke detec	tor	
					maintenance log to be filed in		
					life safety binder as part of the		
					facility's preventive maintenan		
					program. If any issues are		
					discovered, they will be addre	ssed	
					and resolved immediately. Th		
					maintenance supervisor/desig		
					will review with the administra		
					the inspection results.		
					The administrator will monitor		
					adherence to the preventative		
					maintenance schedule and		
					validate the preventative		
					maintenance documentation is	s in	
					place.		
					·		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					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	nly	
					QAPI meeting. Inspection resu	ults	
					and system components will b	е	
					reviewed by the QAPI commit	tee	
					with subsequent plans of		
					correction developed and		
					implemented as deemed		
					necessary to ensure complian	ce	
					is maintained.		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED	
		155274	B. W	ING		06/17	/2025	
				OTT	ADDRESS CHEV CE TO THE COL	Щ_		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
\\\\\\		NULLED NUIDOINO EACULTY TO	815 W WASHINGTON ST					
WATERS	OF ROCKPORTS	SKILLED NURSING FACILITY, TH	1⊏	E ROCKPORT, IN 47635				
(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 APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					By what date the systemic			
					changes for each deficiency			
					will be completed?			
					7/10/2025			
			İ					
K 0321	NFPA 101							
SS=E	Hazardous Areas	- Enclosure						
Bldg. 01								
		on and interview, the facility	K 0	321	It is the intent of the facility to		07/10/2025	
	failed to ensure 1 of	f over 10 hazardous area doors,			ensure hazardous area doors	,		
	such as a Laundry r	room door, would close			such as laundry room doors, v	will		
		h automatically into its frame.			completely close and latch			
	This deficient practice could affect over 10				automatically into the frame to	)		
	residents, staff and	visitors.			meet set standards.			
	Findings include:				What corrective action(s) wil	II.		
					be accomplished for those			
		on on 06/17/25 at 12:52 p.m.			residents found to have been	n		
	-	facility with the Administrator			affected by the deficient			
		irector, the Laundry room			practice?			
		h opens into the corridor next			On 7/2/2025 the maintenance	!		
		exit door, did not close			director/designee repaired the			
		h automatically when tested			laundry room door to ensure it	t self		
		ed on interview at 12:52 p.m.,			closes and latches into its frar	ne		
		rector acknowledged the			to meet set standards.			
	•	did not close completely and			Administrator verified work on			
	latch automatically	and said he would fix it as			7/2/2025.			
	soon as possible.							
	_	viewed with the Administrator			How other residents having			
		irector during the exit			potential to be affected by the			
	conference.				same deficient practice will l			
					identified and what correctiv	'e		
	3.1-19(b)				action(s) will be taken?			
					All residents, staff and visitors			
					have the potential to be affect	ed		
					but none were.			
					What measures will be put in	ito		
					place and what systemic		1	

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	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPL 06/17	ETED
	OF ROCKPORT	R SKILLED NURSING FACILITY, T	815 W	ADDRESS, CITY, STATE, ZIP C WASHINGTON ST PORT, IN 47635	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				changes will be made ensure that the deficie practice does not rece On 7/2/2025 the admir inserviced the mainten supervisor/designee/al requirement to ensure area doors are provide closing devices and lat frame to meet set stan. The maintenance supervisor/designee w hazardous areas are p self closing devices an the frame as part of the monthly preventative in program and documen inspection results as a If any issues are discovill be addressed and immediately. The main supervisor/designee w with the administrator to inspection results. The administrator will radherence to the preventative maintenance schedule validate the preventative maintenance document place.  How the corrective act will recur, i.e., what quality assurance program we into place?  The inspection results presented by the main director/designee to the director directo	ent ur? nistrator ance Il staff on the hazardous ed with self tch into their dards.  ill ensure provided with ed latch into e facility's naintenance et those ppropriate. vered, they resolved etenance ill review the monitor entative e and ve ntation is in  ction(s) ensure the not ey vill be put will be tenance	

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MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
	155274	B. WING		06/17/2025
		<u> </u>		
ROVIDER OR SUPPLIER	1			
OF ROCKPORT S	SKILLED NURSING FACILITY, TI	HE ROCK	PORT, IN 47635	
SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	
*			CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	DATE
			administrator monthly and the administrator will present the inspection results at the month QAPI meeting. Inspection results and system components will be reviewed by the QAPI commit with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	hly ults pe ttee
NFPA 101 Cooking Facilities				
failed to ensure their available to show 1 was inspected semined. Edition, Standard for Protection of Communication 11.4 states the inspected for greet trained, qualified, and acceptable to the authorized and in accordance with Schedule for Inspection of the experimental systems seminantially. NFP inspection, if the experimental systems with the experimental systems with the experimental systems and the experimental systems with the experimental systems.	re was documentation of 1 kitchen exhaust systems annually. NFPA 96, 2011 or Ventilation Control and Fire mercial Cooking Operations, the entire exhaust system shall case buildup by a properly and certified person(s) thority having jurisdiction with Table 11.4. Table 11.4, stion for Grease Buildup, rving moderate volume shall be inspected PA 96, 11.6.1 states, upon haust system is found to be deposits from grease laden nated portions of the exhaust	K 0324	It is the intent of the facility to ensure documentation is avail to show kitchen exhaust syste are inspected semiannually to meet set standards.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  On 7/2/2025 the maintenance supervisor/designee ensured semiannual inspections for the range hood exhaust system a done every 6 months and are documented to meet set standards. The administrator verified work on 7/2/2025	ems  II  n  e e re
	NFPA 101 Cooking Facilities Based on record revaliable to show 1 was inspected semisedition, Standard for Protection of Communication, Section 11.4 states to be inspected for green trained, qualified, a acceptable to the au and in accordance with the section of	IDENTIFICATION NUMBER 155274  PROVIDER OR SUPPLIER  SOF ROCKPORT SKILLED NURSING FACILITY, TI  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	TOF DEFICIENCIES OF CORRECTION    STREET	TO F DEFICIENCIES OF CORRECTION DENTIFICATION NUMBER 155274  ROVIDER OR SUPPLIER SOF ROCKPORT SKILLED NURSING FACILITY, THE  SUMMARY STATEMENT OF DEFICIENCIE (REACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION  REGULATORY OR LSC IDENTIFYING INFORMATION  NEPA 101 Cooking Facilities  Based on review and interview, the facility failed to ensure there was documentation available to show I of I kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust systems was inspected of grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4. Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system is found to be contaminated portions of the exhaust system is found to be contaminated portions of the exhaust system is found to be contaminated portions of the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated with deposits f

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qualified, and certified person(s) acceptable to the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155274	B. W	NG		06/17/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST		
WATED		SKILLED NILIBRING EVOILITY TH	_		PORT, IN 47635		
WATERS	S OF ROCKPORTS	SKILLED NURSING FACILITY, TH		ROCKE	OR1, IN 47635		
(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
		risdiction. Hoods, grease					
		ins, ducts, and other			How other residents having	the	
	appurtenances shall be cleaned to remove				potential to be affected by th	ie	
	combustible contaminants prior to surfaces				same deficient practice will be	Эе	
	becoming heavily contaminated with grease or				identified and what correctiv	е	
	oily sludge. After the exhaust system is cleaned,				action(s) will be taken?		
	it shall not be coated with powder or other				All residents, staff and visitors		
		n exhaust cleaning service is			have the potential to be affect	ed	
		howing the name of the			but none were.		
	servicing company, the name of the person						
	performing the work, and the date of inspection or				What measures will be put in	nto	
	cleaning shall be maintained on the premises.				place and what systemic		
	This deficient practice could affect kitchen staff				changes will be made to		
	and residents, staff, and visitors while in the main				ensure that the deficient		
	dining room.				practice does not recur?		
					On 7/2/2025 the administrator	•	
	Findings include:				inserviced the maintenance		
					supervisor/dietary		
		view on 06/17/25 at 11:50 a.m.			manager/designee to ensure t		
		ator and Maintenance Director			maintain the range hood exha	ust	
		two semi annual inspection			system and ensure the		
	_	r review during the past twelve			semiannual inspection is		
		ge hood exhaust system,			conducted every 6 months to	meet	
	_	ctions were almost nine			set standards.		
	• •	5/24 and 05/04/25. Based on			The maintenance supervisor a		
		te of record review, the			dietary manager will ensure to		
		tor said he started work at the			maintain the range hood exha	uSī	
		I noticed the vendor was late			system and ensure the		
		25 inspection. So he called the e to get the vendor to the			semiannual inspections are	_	
		9			conducted every 6 months as		
	facility in May 202	J.			part of the facility's semiannua		
	This finding was ro	viewed with the Administrator			preventive maintenance progr		
		viewed with the Administrator Director during the exit			and document those inspection results as appropriate. If any	111	
	conference.	nector during the exit				ill he	
	conference.				issues are discovered, they will addressed and resolved	ııı D <del>C</del>	
	3.1-19(b)				immediately. The maintenance	<b>`</b>	
	J.1-19(U)				supervisor/designee will review		
					with the administrator the resu		
						ii(S	
	1		1		of the inspection.		

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C	x3) date survey completed 06/17/2025
	ROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				The administrator will monitor the adherence to the preventive maintenance schedule and validate the preventive maintenance documentation is place.	
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place?  The monitoring results will be presented by the administrator the monthly QAPI meeting. Inspection results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	<b>t</b> at
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm Syster Maintenance	m - Testing and			
	failed to maintain 1 accordance with N Sections 19.3.4.5.1 14.3.1 states that ut 14.3.2, visual inspeaccordance with the	on and interview, the facility I of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section nless otherwise permitted by ections shall be performed in e schedules in Table 14.3.1, or red by the authority having	K 0345	It is the intent of the facility to ensure to maintain the fire alarr systems in accordance with NFPA 72, as required by LSC 1 sections 19.3.4.5.1 and 9.1 to meet set standards.  What corrective action(s) will	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155274 B. WING 06/17/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 815 W WASHINGTON ST WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE ROCKPORT, IN 47635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE jurisdiction. Table 14.3.1 states that the following be accomplished for those must be visually inspected semi-annually: residents found to have been a. Control unit trouble signals affected by the deficient b. Remote annunciators practice? c. Initiating devices (e.g. duct detectors, manual On 7/2/2025 the maintenance fire alarm boxes, heat detectors, smoke detectors, supervisor/designee repaired the ceiling mounted heat detector in d. Notification appliances the laundry room to ensure it is e. Magnetic hold-open devices secured to the ceiling to meet This deficient practice could affect mostly laundry se4t standards. The administrator staff, plus any residents within the adjacent verified the work on 7/2/2025. smoke compartment. How other residents having the Findings include: potential to be affected by the same deficient practice will be Based on observations on 06/17/25 at 12:50 p.m. identified and what corrective during a tour of the facility with the Administrator action(s) will be taken? and Maintenance Director, there was a ceiling All residents, staff and visitors mounted heat detector in the laundry room have the potential to be affected hanging loosely from its wires and not secured to but none were. the ceiling. Based on interview at 12:50 p.m., the Maintenance Director acknowledged the heat What measures will be put into detector not being flush with the ceiling and said place and what systemic he would correct it as soon as possible. changes will be made to ensure that the deficient This finding was reviewed with the Administrator practice does not recur? and Maintenance Director during the exit On 7/2/2025 the administrator conference. inserviced the maintenance supervisor/designee on the 3.1-19(b) requirement to ensure to maintain the fire alarm systems including ensuring ceiling mounted heat detectors are secured to the ceiling to meet set standards. Maintenance supervisor/licensed fire alarm contractor/designee will ensure to maintain the fire alarm

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systems including ensuring ceiling mounted heat detectors are secured to the ceiling as part of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 06/17/2025					
		ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	≣	815 W V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ORT, IN 47635		
		S OF ROCKPORT S SUMMARY (EACH DEFICIEN			815 W V	WASHINGTON ST	e sults re ssed e nee tor he ut	(X5) COMPLETION DATE
						By what date the systemic changes for each deficiency		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155274	B. WI	NG		06/17	/2025
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			WASHINGTON ST		
WATERS	OF ROCKPORT S	SKILLED NURSING FACILITY, THE	:		PORT, IN 47635		
WATERC	or Rooki oki c		_	ROOK			
(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)		DATE
					7/10/2025		
I/ 0050	NIEDA 404						
K 0353	NFPA 101						
SS=F	Sprinkler System -	- Maintenance and Testing					
Bldg. 01	1 Dagad1	ention and intermitary 41 -	17.00	2.52	It is the intent of the feetile of		07/10/2025
		ation and interview, the	K 03	555	It is the intent of the facility to	de	07/10/2025
	_	sure a sprinkler head in 1 of 7			ensure sprinkler heads in smo	ке	
	_	ts covered with a foreign			compartments covered with a	and	
	_	ed. NFPA 25, 2011 edition, at shall not show signs of			foreign material are replaced a		
	_	ee of corrosion, foreign			to ensure sprinkler system ga on the sprinkler system riser a	-	
	_	d physical damage; and shall				ii <del>C</del>	
	_				replaced every 5 years or documented and tested every	5	
	be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at				years by comparison with a	3	
		that shows signs of any of			calibrated gauge and to ensur	o the	
		be replaced: (1) Leakage (2)			ceiling in sprinklered smoke	e uie	
		cal Damage (4) Loss of fluid in			compartments are maintained	l to	
		responsive element (5)			allow sprinkler heads to functi		
	_	g unless painted by the			their full capability to meet set		
		arer. This deficient practice			standards.		
	-	kitchen staff, plus all residents			Staridards.		
	while in the adjacen				What corrective action(s) will	I	
	J	8			be accomplished for those	· <del>-</del>	
	Findings include:				residents found to have been	n	
	C				affected by the deficient		
	Based on observation	on on 06/17/25 at 2:02 p.m.			practice?		
		facility with the Administrator			on 7/2/2025 the maintenance		
		irector, there was one pendent			supervisor/sprinkler		
	sprinkler head in the	e kitchen directly over the			contractor/designee repaired	the	
	-	ront of the stove that was			sprinkler head in the kitchen		
	covered with what a	appeared to be grease build up			directly over the steam table t	0	
		was confirmed by the			meet set standards. The		
	Maintenance Direct				administrator verified the work	on	
					7/2/2025.		
	This finding was re-	viewed with the Administrator			On 7/2/2025 the maintenance		
	and Maintenance D	irector during the exit			supervisor/sprinkler		
	conference.				contractor/designee replaced	four	
					sprinkler gauges on the sprink	der	
	3.1-19(b)				system riser to meet set		
			l		standards. The administrator		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155274 B. WING 06/17/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 815 W WASHINGTON ST WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE ROCKPORT, IN 47635 (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 2. Based on observation and interview, the verified the work on 7/2/2025. facility failed to ensure 4 of 4 sprinkler system On 7/2/2025 the maintenance gauges on the sprinkler system riser were replaced supervisor/designee repaired the every 5 years or documented as tested every 5 two holes in the damaged ceiling years by comparison with a calibrated gauge. with one hour fire rated material in NFPA 25, Standard for the Inspection, Testing, the boiler room to meet set and Maintenance of Water-Based Fire Protection standards. The administrator Systems, 2011 Edition, Section 5.3.2.1 states verified the work on 7/3/2025. gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of How other residents having the the full scale shall be recalibrated or replaced. potential to be affected by the This deficient practice could affect all residents, same deficient practice will be staff, and visitors. identified and what corrective action(s) will be taken? Findings include: All residents, staff and visitors have the potential to be affected Based on observation on 06/17/25 at 1:00 p.m. but none were. during a tour of the facility with the Administrator and Maintenance Director, all four sprinkler What measures will be put into gauges on the sprinkler system riser had dates of place and what systemic 2019 which were past due for replacement or changes will be made to recalibration. No recalibration date information ensure that the deficient was affixed to the sprinkler system gauges. Based practice does not recur? on interview at 1:00 p.m., the Maintenance On 7/2/2025 the administrator Director confirmed the sprinkler system gauges inserviced the maintenance had not been recalibrated within the most recent supervisor/designee on the five year period and would have the gauges requirement to ensure to maintain replaced as soon as possible. the sprinkler system and ensure sprinkler heads are not covered This finding was reviewed with the Administrator with dust/dirt, ensuring sprinkler and Maintenance Director during the exit gauges on the riser are conference. recalibrated or replaced every 5 years and to ensure there are no 3.1-19(b)penetrations or damaged ceilings to meet set standards. 3. Based on observation and interview, the The maintenance facility failed to ensure the ceiling in 1 of 7 supervisor/designee will ensure to sprinklered smoke compartments was maintained maintain the sprinkler system and to allow sprinkler heads to function to their full ensure sprinkler heads are not

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	COMPLETED	
		155274	B. WIN	NG		06/17/	/2025	
			<del></del>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R			WASHINGTON ST			
WATERS		SKILLED NURSING EACH ITY THE	_					
WATERS	OF ROCKFORT	SKILLED NURSING FACILITY, TH	_	KUCKF	PORT, IN 47635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	capability. This de	ficient practice could affect			covered by dust/dirt, ensure			
	over 10 residents in	the same smoke compartment.			sprinkler gauges on the riser a	are		
					recalibrated or replaced every	5		
	Findings include:				years , and ensure there are n	10		
					penetrations or damaged ceili	ngs		
		on on 06/17/25 at 12:45 p.m.			as part of the facility's annual			
_		facility with the Administrator			preventive maintenance progr	am		
		Director, there were two holes			and document the inspection			
		s by six inches and a damaged			results as appropriate. If any			
		between the drywall sections			issues are discovered, they wi	III be		
		. Based on interview at 12:45			addressed and resolved			
	*	nce Director acknowledged the			immediately. The maintenance			
		ithin the Boiler Room and			supervisor/designee will revieve	N		
	agreed it will need	to be repaired.			with the administrator the			
					inspection results.			
	_	eviewed with the Administrator			The administrator will monitor			
		Director during the exit			adherence to the preventative			
	conference.				maintenance schedule and			
	2.1.10(1-)				validate the preventative	_ :		
	3.1-19(b)				maintenance documentation is	3 IN		
					place.			
					Have the commention action (a)			
					How the corrective action(s)			
					will be monitored to ensure t	.rie		
					deficient practice will not			
					recur, i.e., what quality assurance program will be p			
						ut		
					into place? The inspection results will be			
					presented by the maintenance	د		
					supervisor/designee to the	,		
					administrator monthly and the			
					administrator will present the			
					inspection results at the month	nlv		
					QAPI meeting. Inspection resu	•		
					and system components will b			
					reviewed by the QAPI commit			
					with subsequent plans of			
					correction developed and			
					implemented as deemed			
1	l		1		Ι .		İ	

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, ´		l í	` '			3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER			01			
	155274	B. WI	NG		06/17	/2025	
		STREET ADDRESS, CITY, STATE, ZIP COD  815 W WASHINGTON ST  ROCKPORT, IN 47635					
SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
				is maintained.  By what date the systemic			
K 0374 NFPA 101 SS=F Subdivision of Building Spaces - Smoke							
Barrie Based on observation failed to ensure 2 of doors would close or resistant barrier. LSt that doors in smoke LSC, Section 8.5.4. doors in smoke barrileaving only the min proper operation who restrict the movemer practice could affect and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct a. At 1:40 p.m., the rooms 107 and 108 tested several times between the doors who have been the doors who have been the doors who have a said 9 did in tested several times not close on its own magnetic holder. The at least eight inches	on and interview, the facility 6 6 sets of smoke/fire barrier completely to form a smoke 6 C, Section 19.3.7.8 requires barriers shall comply with LSC, Section 8.5.4.1 requires ciers to close the opening nimum clearance necessary for nich is defined as 1/8 inch to nt of smoke. This deficient t all residents, as well as staff  ons on 06/17/25 during a tour the Administrator and or, the following was noted: e set of smoke barrier doors near did not close completely when There was a half inch gap when closed fully. set of smoke barrier doors near ot close completely when The west side door would when released from the the bottom of the door drug for on the floor before it finally	K 0.	374	doors will close completely to a smoke resistant barrier to m set standards.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 6/30/2025 the maintenance supervisor/designee repaired set of smoke barrier doors near rooms 107 and 108 to ensure close completely and installed fire rated seal to ensure there no gaps when the door is fully closed. The maintenance supervisor/designee also repathe set of smoke barrier doors near rooms 8 and 9 to ensure close properly to meet set standards. The administrator verified this work on 6/30/2025.	form leet  II  n  e the lar they la are are dired in they  5.	07/10/2025	
	NFPA 101 Subdivision of Bui Based on observation failed to ensure 2 of doors would close or resistant barrier. LSt that doors in smoke LSC, Section 8.5.4. doors in smoke barrileaving only the min proper operation where the doors would affect and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of Builbard of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of Builbard of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of the facility with the Maintenance Direct and visitors.  Findings include:  Based on observation of Builbard of	DENTIFICATION NUMBER 155274  PROVIDER OR SUPPLIER  S OF ROCKPORT SKILLED NURSING FACILITY, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 2 of 6 sets of smoke/fire barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors.	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 2 of 6 sets of smoke/fire barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors.  Findings include:  Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted:  a. At 1:40 p.m., the set of smoke barrier doors near rooms 107 and 108 did not close completely when tested several times. There was a half inch gap between the doors when closed fully.  b. At 2:40 p.m. the set of smoke barrier doors near rooms 8 and 9 did not close completely when tested several times. There was a half inch gap between the doors when closed fully.  b. At 2:40 p.m. the set of smoke barrier doors near rooms 8 and 9 did not close completely when tested several times. The west side door would not close on its own when released from the magnetic holder. The bottom of the door drug for at least eight inches on the floor before it finally closed on its own. It had to be manually closed	ROVIDER OR SUPPLIER  SOF ROCKPORT SKILLED NURSING FACILITY, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 2 of 6 sets of smoke/fire barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors.  Findings include:  Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted:  a. At 1:40 p.m., the set of smoke barrier doors near rooms 107 and 108 did not close completely when tested several times. There was a half inch gap between the doors when closed fully.  b. At 2:40 p.m. the set of smoke barrier doors near rooms 8 and 9 did not close completely when tested several times. There was a half inch gap between the doors when released from the magnetic holder. The bottom of the door drug for at least eight inches on the floor before it finally closed on its own. It had to be manually closed	A BUILDING 155274  ROVIDER OR SUPPLIER  S OF ROCKPORT SKILLED NURSING FACILITY, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  NFPA 101  Subdivision of Building Spaces - Smoke Barrie  Based on observation and interview, the facility finiled to ensure 2 of 6 sets of smoke/fire barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors.  Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted:  A 11:40 p.m., the set of smoke barrier doors near rooms 107 and 108 did not close completely when tested several times. There was a half inch gap between the doors when closed fully.  B. A2:40 p.m. the set of smoke barrier doors near rooms 8 and 9 did not close completely when tested several times. The west side door would not close on its own when released from the magnetic holder. The bottom of the door dury for at least eight inches on the floor before it finally closed on its own. It had to be manually closed	ROYIDER OR SUPPLIER  SOF ROCKPORT SKILLED NURSING FACILITY, THE  SUMMARY STATEMENT OF DEFICIENCE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101  Subdivision of Building Spaces - Smoke Barrie  Based on observation and interview, the facility and close completely to form a smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors.  Based on observations on 06/17/25 during a tour of the facility with the Administrator and Maintenance Director, the following was noted:  a. At 1-40 p.m., the set of smoke barrier doors near rooms 107 and 108 did not close completely when tested several times. There was a half inch gap between the doors when closed fully.  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635  TO STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS AND STATE ADDRESS	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE:			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155274	B. WI	NG		06/17	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			WASHINGTON ST		
WATERS	OF ROCKPORT	SKILLED NURSING FACILITY, THE	Ξ		PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	he Maintenance Director at			identified and what correctiv	e	
	2:40 p.m.				action(s) will be taken?		
					All residents, staff and visitors		
	_	eviewed with the Administrator			have the potential to be affect		
	and Maintenance Director during the exit conference.				but none were. On 7/2/2025 th		
					maintenance director/designe		
					inspected all smoke barrier do		
	3.1-19(b)				throughout the facility and fou	na	
					no other negative findings.		
					What measures will be put ir	nto	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					On 7/2/2025 the administrator		
					inserviced the maintenance		
					supervisor/designee and all st		
					on the requirements that smol	ke	
					barrier doors must close		
					completely to meet set standa		
					Maintenance director/designe		
					inspect all smoke barrier door		
					throughout the facility monthly		
					ensure they close completely		
					part of the facility's preventative	/ <del>C</del>	
					maintenance program and document those inspection re	eulte	
					as appropriate. If any issues a		
					discovered, they will be addre		
					and resolved immediately. The		
					maintenance supervisor/desig		
					will review with the administra		
					the inspection results.		
					The administrator will monitor		
					adherence to the preventive		
					maintenance schedule and		
					validate the preventative		
					maintenance documentation is	s in	
					nlace		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
ANDIEM	or connection	155274	B. WING		01	06/17/	
	PROVIDER OR SUPPLIES	R SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be position place?  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 QAPI meeting. Inspection results and system components will be reviewed by the QAPI committed with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	ut lly llts e ee	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						
<b>3</b> *	failed to ensure 8 or complete documen fire alarm signal to department during 19.7.1.4 requires fire cocupancies shall if ire alarm signal and	view and interview, the facility f 12 fire drill reports included tation of the transmission of a the monitoring company/fire the past twelve months. LSC re drills in health care include the transmission of the d simulation of emergency efficient practice could affect all	K 0712		It is the intent of the facility to ensure fire drills include the verification of transmission of t fire alarm signal to the monitor station to meet set standards.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	ing	07/10/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/17/2025		
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, TH	8	315 W V	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST ORT, IN 47635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	Findings include:  Based on review of on 06/17/25 at 10:5 and Maintenance D reports performed d were not provided v transmission of the company. Based or record review, the N confirmed there was 8 of 12 fire drill repof the alarm was recompany.  This finding was recorded.	the facility's fire drill reports 0 a.m. with the Administrator irector present, 8 of 12 fire drill turing the past 12 month period with documentation for the alarm to the monitoring interview at the time of Maintenance Director s no information included with oorts to verify that transmission ceived by the monitoring wiewed with the Administrator irector during the exit		ΓAG	practice? On 7/7/2025 the maintenance director will conduct a fire drill all 3 shifts at varying times and will include the transmission of alarm to the monitoring comparand documented results on the drill log sheet in the facility's lift safety binder to meet set standards. The administrator verify the work on 7/7/2025.  How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?  All residents, staff and visitors have the potential to be affected but none were.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur?  On 7/2/2025 the administrator inserviced the maintenance supervisor on the requirement ensure fire drills have completed documentation including the transmission of the fire alarm signal to the monitoring compart to meet set standards.  The maintenance supervisor/administrator/designal ensure fire drills have completed to the monitoring compart to meet set standards.  The maintenance supervisor/administrator/designal to the monitoring compart to the fire alarm signal to the monitoring compart to	on d f the any e fire fe will the ne ded atto	DATE

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155274			ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/17/2025	
	ROVIDER OR SUPPLIES	SKILLED NURSING FACILITY, TH	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635		
(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)	DATE	
K 0761	NFPA 101			as part of the facility's monthly preventative maintenance progrand document those inspection results as appropriate. If any issues are discovered, they will addressed and resolved immediately. The maintenance supervisor/designee will review with the administrator the inspection results.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?  The fire drill documentation will presented by the maintenance supervisor/designee to the administrator and the administrator will present the inspection results at the month QAPI meeting. Inspection results and system components will be reviewed by the QAPI commit with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	gram n II be e N he ut III be s nily ults e tee	
SS=E Bldg. 01		pection & Testing - Doors				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/17/2025	
NAME OF I	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST		
WATERS	OF ROCKPORT	SKILLED NURSING FACILITY, TH	lE		PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE	
		on, record review, and	K 0	761	It is the intent of the facility to	07/10/2025	
		ity failed to ensure an annual			ensure an annual inspection a		
	•	ng of 1 of 1 oxygen room fire			testing of oxygen room fire do	or	
		completed in accordance with			assemblies are completed in		
		Communicating openings in			accordance with LSC 19.1.1.4	.1.1	
	-	rs required by 19.1.1.4.1 shall be			to meet set standards.		
	permitted only in corridors and shall be protected					_	
	by approved self-closing fire door assemblies.				What corrective action(s) wil	I	
	(See also Section 8.3.) LSC 8.3.3.1 Openings				be accomplished for those		
	*	fire protection rating by Table			residents found to have been	ו	
	8.3.4.2 shall be protected by approved, listed,				affected by the deficient		
	labeled fire door assemblies and fire window assemblies and their accompanying hardware,				practice?		
					On 7/2/2025 the maintenance		
	including all frames, closing devices, anchorage,				supervisor conducted the annu	ual	
	and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other				inspection of the oxygen		
	· ·				transfilling room fire door		
		es, except as otherwise			assembly and documented the		
	_	de. NFPA 80 5.2.1 states fire			results in the life safety binder	TO	
		all be inspected and tested not and a written record of the			meet set standards.		
	-	signed and kept for inspection			Have other residents begins	uh a	
	_	80, 5.2.4.1 states fire door			How other residents having to		
		visually inspected from both			potential to be affected by the same deficient practice will be		
		overall condition of door			identified and what correctiv		
	assembly.	overall condition of door			action(s) will be taken?	<b>-</b>	
	assemory.				All residents, staff and visitors		
	NFPA 80 5242 s	tates as a minimum, the			have the potential to be affected		
	following items sha				but none were.		
	_	or breaks exist in surfaces of			but hone were.		
	either the door or fi				What measures will be put in	ito	
		light frames, and glazing beads			place and what systemic		
		rely fastened in place, if so			changes will be made to		
	equipped.	1,			ensure that the deficient		
		e, hinges, hardware, and			practice does not recur?		
		reshold are secured, aligned,			On 7/2/2025 the administrator		
		er with no visible signs of			inserviced the maintenance		
	damage.	5			supervisor to ensure an annua	al	
	(4) No parts are mi	ssing or broken.			inspection for the fire doors is		
		s do not exceed clearances			completed including the oxyge		
	listed in 4.8.4 and 6.3.1.7.				transfilling room fire door and		

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AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JILDING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  06/17/2025	
		155274	B. W.	ING		06/17/	72025
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, THI	=	ROCKE	PORT, IN 47635		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		g device is operational; that is,			documented to meet set		
		npletely closes when operated			standards.		
	from the full open p				The maintenance		
		is installed, the inactive leaf			supervisor/designee will ensu		
	closes before the active leaf.				annual inspection of the fire d		
		are operates and secures the			is completed and documented	d as	
	door when it is in the	-			part of the facility's annual		
	•	vare items that interfere or			preventive maintenance progr		
		are not installed on the door or			and document those inspection	n	
	frame.	~			results as appropriate. If any		
	(10) No field modifications to the door assembly				issues are discovered, they w	ill be	
	-	ed that void the label.			addressed and resolved		
	(11) Gasketing and edge seals, where required, are				immediately. The maintenance		
	-	their presence and integrity.			supervisor/designee will revie	W	
	-	tice could affect mostly staff			with the administrator the		
		Unit is currently closed to			inspection results.		
	-	or 2 residents while using the			The administrator will monitor		
	Therapy gym.				adherence to the preventative	)	
	Findings in ded.				maintenance schedule and		
	Findings include:				validate the preventative	_ :	
	Dogod on mooned nor	view on 06/17/25 at 12:15 p.m.			maintenance documentation is	s in	
		ator and Maintenance Director			place.		
		was unable to provide			How the corrective action(s) will be monitored to ensure to		
		an annual inspection of the			deficient practice will not	uie	
		room fire door assembly for the			recur, i.e., what quality		
		od or prior. Based on interview			assurance program will be p	urt	
		d review, the Maintenance			into place?	ut	
		was no documentation of an			The inspection results will be		
		of the oxygen transfilling room			presented by the maintenance	Э	
	_	available to review for the past			supervisor/designee to the	-	
		Based on observations during a			administrator monthly and the	<b>!</b>	
	*	between 12:40 p.m. and 3:15			administrator will present the		
	p.m., there was one oxygen transfilling room fire		1		inspection results at the month	hly	
	door assembly noted in the facility.		1		QAPI meeting. Inspection resi	-	
					and system components will b		
	This finding was re	eviewed with the Administrator			reviewed by the QAPI commit		
		Director during the exit			with subsequent plans of		
	conference.				correction developed and		
					implemented as deemed		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155274	B. WI	NG _		06/17/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
WATERS	OF ROCKPORT S	KILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				necessary to ensure complian	ce	
					is maintained.		
					By what date the systemic		
					changes for each deficiency		
					will be completed?		
					7/10/2025		
K 0914	NFPA 101						
SS=F		s - Maintenance and					
Bldg. 01	Testing						
		on, record review, and	K 09	914	It is the intent of the facility to		07/10/2025
		ty failed to ensure complete			ensure complete documentation		
	documentation was				for all non-hospital grade elect		
		lectrical receptacles in all ons tested at least annually.			receptacles in all resident roor locations are tested at least	n	
		are Facilities Code 2012 Edition,			annually to meet set standards		
		ates receptacles not listed as			annually to meet set standards	۶.	
		atient bed locations and in			What corrective action(s) wil	ı	
		p sedation or general			be accomplished for those	•	
		istered, shall be tested at			residents found to have beer	1	
		ling 12 months. Additionally,			affected by the deficient		
	Section 6.3.3.2, Rec	ceptacle Testing in Patient Care			practice?		
	-	physical integrity of each			On 7/3/2025 the maintenance		
	•	confirmed by visual inspection.			supervisor/designee complete	d the	
		e grounding circuit in each			annual resident room receptad	le	
	-	shall be verified. Correct			testing including itemizing the		
		nd neutral connections in			room location and the recepta		
	-	otacle shall be confirmed; and			locations in each room to mee		
		e grounding blade of each			set standards. The administrat	or	
	•	e (except locking-type e not less than 115 grams (4			verified the work on 7/4/2025.		
	- '	ient practice could affect all			How other residents having t	·ho	
	residents.	iem praetice could affect all			How other residents having t potential to be affected by th		
	residents.				same deficient practice will b		
	Findings include:				identified and what corrective		
					action(s) will be taken?	-	
	Based on record rev	riew on 06/17/25 at 12:30 p.m.			All residents, staff and visitors		
		ator and Maintenance Director			have the potential to be affected		
present, there was some documentation available				but none were.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING <u>01</u> B. WING				X3) DATE SURVEY COMPLETED 06/17/2025	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	815 W \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635			
(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	
	of an annual resider hospital-grade recepteriod, however, the 18 of the 45 resident on interview at the Maintenance Direct resident rooms were receptacles as far as Director said he condocumentation to sl NFPA 99, Receptact met with all pertine 12 month period for room receptacles. I between 12:40 p.m. the facility with the Maintenance Direct six electrical recept.	nt room receptacle test for non otacles for the past 12 month e documentation only included it room receptacle tests. Based time of record review, the or said electrical receptacles in e not hospital-grade is he knew. The Maintenance ald not find any more now that annual testing per ele Testing requirements was int information within the past or the remaining 27 resident Based on observations and 3:15 p.m. during a tour of			What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? On 7/2/2025 the administrator inserviced the maintenance director/designee on the requirement to ensure the annesident room receptacle testic completed to meet set standad Maintenance supervisor/designe will ensure the annual resident room receptacle testing is completed and documented a part of the facility's annual preventive maintenance progrand document those inspection results as appropriate. If any issues are discovered, they waddressed and resolved immediately. The maintenance supervisor/designee will reviewith the administrator the inspection results.  The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation in place.  How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be pinto place?  The inspection results will be results will be into place?	nual ng is rds. gnee ut s ram on ill be e w		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		•
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155274	B. WI	NG		06/17/2025		
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			•
NAME OF I	PROVIDER OR SUPPLIER		815 W WASHINGTON ST					
WATERS	OF ROCKPORT S	KILLED NURSING FACILITY, TH	Ε		PORT, IN 47635			
(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)		DATE	-
					presented by the maintenance supervisor/designee to the administrator monthly and the administrator will present the inspection results at the month QAPI meeting. Inspection results and system components will be reviewed by the QAPI commit with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	hly ults be tee		
K 0916 SS=F Bldg. 01	Based on observation failed to ensure 1 of provided with an alar readily observed by regular work station NFPA 99, 2012 Edit Code, at 6.4.1.1.17 that is storage batter to operate outside of location readily observed at a regular work state be hard-wired to incemergency or auxilia (1) Individual visual	on and interview, the facility I emergency generator was arm annunciator in a location operating personnel at a such as a nurses' stations. tion, Health Care Facilities requires a remote annunciator ry powered shall be provided f the generating room in a served by operating personnel ation. The annunciator shall licate alarm conditions of the ary power source as follows: al signals shall indicate: sency or auxiliary power source	K 09	916	It is the intent of the facility to ensure emergency generator in provided with an alarm annual in a location readily observed operating personnel at a regul work station, such as a nurses station, to meet set standards.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  On 7/8/2025 the licensed generator contractor will move	ciator by lar s	07/10/2025	

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is operating to supply power to load.

b. When the battery charger is malfunctioning.

(2) Individual visual signals plus a common

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remote generator annunciator

nurses station to meet set

panel to the supervised east unit

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		•	•			
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155274	B. WING		06/17/2025	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		WASHINGTON ST		
\A/ATEDC		EVILLED MUDEING FACILITY TH				
WATERS	OF RUCKPURTS	SKILLED NURSING FACILITY, THI	E ROCKE	PORT, IN 47635		
(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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	audible signal to wa	arn of an engine-generator		standards. The administrator	will	
	alarm condition sha	all indicate:		verify the work on 7/8/2025.		
	a. Low lubricating	oil pressure.				
	b. Low water temp	-		How other residents having	the	
	c. Excessive water			potential to be affected by the		
		the main fuel storage tank		same deficient practice will l		
		4-hour operating supply.		identified and what corrective		
	e. Overcrank (faile			action(s) will be taken?		
	f. Overspeed.	,		All residents, staff and visitors		
	-	ork station will be unattended		have the potential to be affect		
		lible and visual derangement		but none were.		
		y labeled, shall be established		Succession were:		
		nonitored location. This		What measures will be put in	nto	
	-	shall activate when any of the		place and what systemic		
	-	1.17(1) and (2) occur but need		changes will be made to		
		onditions individually. This		ensure that the deficient		
		ould affect all residents, as well		practice does not recur?		
	as visitors and staff			On 7/2/2025 the administrator		
	us visitors und sturi	in the facility.		inserviced the maintenance		
	Findings include:			supervisor and all staff on the		
	i mamga meraac.			requirement to ensure genera		
	Based on observation	on on 06/17/25 at 1:50 p.m.		annunciator panels are in prop		
		facility with the Administrator		operating conditions to meet s		
	_	Pirector, the remote generator		standards.		
		vas located at the West		The maintenance director will		
	•	ich was not currently in		ensure generator annunciator		
		sked, the Administrator said		panels are in proper operating		
	-	tation is currently closed due		condition as part of the facility	•	
		nere are no residents currently		weekly preventive maintenance		
		nd the nearest Nurse's Station		program and document those		
		her side of the facility on the		inspection results as appropria		
		erator annunciator panel would		If any issues are discovered, t		
	_	he East Unit if activated.		will be addressed and resolve	•	
	not be noute from t	22 2 2 2 11 11 activated.		immediately. The maintenance		
	This finding was re	viewed with the Administrator		supervisor/designee will revie		
	_	Firector during the exit		with the administrator the	vv	
	conference.	nector during the exit				
	conference.			inspection results.		
	3.1-19(b)			The administrator will monitor adherence to the preventative		
	1 2.1-19(1))		1	L adderence to the preventative	· •	

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maintenance schedule and

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (	X3) DATE SURVEY COMPLETED 06/17/2025
	PROVIDER OR SUPPLIED	SKILLED NURSING FACILITY, TH	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				validate the preventive maintenance documentation is place.	in
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place?  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 monthl QAPI meeting. Inspection result and system components will be reviewed by the QAPI committed with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.  By what date the systemic changes for each deficiency will be completed? 7/10/2025	y tts
K 0918 SS=F Bldg. 01	NFPA 101 Electrical System	s - Essential Electric Syste			
j	failed to exercise 1 annually to meet th 2010 Edition, the S Standby Powers Sy 8.4.2 states diesel g	of 1 emergency generator e requirements of NFPA 110, tandard for Emergency and estems, Chapter 8.4.2. Section generator sets in service shall t once monthly, for a minimum	K 0918	It is the intent of the facility to ensure to exercise emergency generator annually to meet the requirements of NFPA 110, 20° edition, the standard for emergency and standby powers systems, chapter 8.4.2 to meet	s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/17/2025		
	PROVIDER OR SUPPLIER	L R SKILLED NURSING FACILITY, THI	STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST HE ROCKPORT, IN 47635				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110		g one of the following		1110	set standards.		Bille
	methods:	g one of the following			Set standards.		
		aintains the minimum exhaust			What corrective action(s) wi	11	
		s recommended by the			be accomplished for those		
	manufacturer	recommended by the			residents found to have bee	n	
	(2) Under operating temperature conditions and at					11	
	not less than 30 percent of the EPS (Emergency				affected by the deficient		
	Power Supply) nam				practice? On 7/3/2025 the maintenance		
		es diesel-powered EPS					
		o not meet the requirements of			supervisor/licensed generator		
		•			contractor/designee complete		
8.4.2 shall be exercised monthly with the available				required load testing to meet	set		
EPSS (Emergency Power Supply System) load and				standards. The administrator			
shall be exercised annually with supplemental				verified the work on 7/3/2025.			
	· ·	Test) at not less than 50 percent			l		
	-	ate kW rating for 30 continuous			How other residents having		
		less than 75 percent of the EPS			potential to be affected by the		
		ng for 1 continuous hour for a			same deficient practice will l		
		f not less than 1.5 continuous			identified and what corrective	⁄e	
		nt practice could affect all			action(s) will be taken?		
	residents, staff, and	visitors.			All residents, staff and visitors		
					have the potential to be affect	ed	
	Findings include:				but none were.		
		view on 06/17/25 at 1:15 p.m.			What measures will be put in	nto	
		ator and Maintenance Director			place and what systemic		
		y load percentage for the			changes will be made to		
		erator was documented less			ensure that the deficient		
	_	l of the past 12 months. Based			practice does not recur?		
		time of record review, the			On 7/2/2025 the administrator	٢	
		tor acknowledged the			inserviced the maintenance		
	-	load on a monthly basis but			supervisor/designee on the		
		% of the name plate rating			requirement to ensure the		
		ionally, the Maintenance			generator's monthly load testi	•	
		lged a load bank test for the			obtains at least 30% of the na		
	-	ccurred within the past 12			plate rating to meet set standa		
	-	ould not be determined when			The maintenance supervisor v		
		d bank test for the generator			ensure the generator's month	ly	
	was performed.				load testing obtains at least 3	0%	
					of the name plate rating as pa	art of	
	This finding was re	viewed with the Administrator			the facility's preventive		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  06/17/2025	
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	815 \	ET ADDRESS, CITY, STATE, ZIP COD W WASHINGTON ST CKPORT, IN 47635	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR			maintenance program and document those inspection re as appropriate. If any issues discovered, they will be addrand resolved immediately. The maintenance supervisor/desi will review with the administrative the results of the inspection. The administrator will monito adherence to the preventative maintenance schedule and validate the preventative maintenance documentation place.  How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be presented by the maintenance director/designee to the administrator monthly and the administrator will present the results of the inspections at the monthly QAPI meeting. Inspecients and system compone will be reviewed by the QAPI committee with subsequent profice of correction developed and implemented as deemed necessary to ensure compliatis maintained.  By what date the systemic changes for each deficiency will be completed?	esults are essed ne gnee ator  r e he ection nts plans
				7/10/2025	[

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		155274	B. WI	NG		06/17/	2025
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD  815 W WASHINGTON ST  ROCKPORT, IN 47635				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure power substitute for fixed rooms. LSC 19.5.1 Section 9.1. LSC 9 and equipment to consider the Electrical Code, 20 400.8 requires that, flexible cords and consubstitute for fixed deficient practice consubstitute for fixed deficient practic	ent - Power Cords and on and interview, the facility ver strips were not used as a wiring in 2 of 45 resident requires utilities to comply with 0.1.2 requires electrical wiring omply with NFPA 70, National 11 Edition. NFPA 70, Article unless specifically permitted, cables shall not be used as a wiring of a structure. This ould affect four residents.  ons on 06/17/25 during a tour the Administrator and tor, the following was noted: ident room 14 had one strip with a TV and phone furthermore, there was a small d into another power strip. dged by the Maintenance in. ident room 12 had a small d into a power strip. This was the Maintenance Director at  viewed with the Administrator firector during the exit	K 09	920	It is the intent of the facility to ensure power strips are not us as a substitute for fixed wiring resident rooms to meet set standards.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  On 6/30/2025 the maintenance supervisor/designee removed power strips from resident room 14 and 12 to meet set standar Administrator verified the work 6/30/2025.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?  All residents, staff and visitors have the potential to be affected but none were.  On 6/30/2025 the maintenance supervisor/designee inspected rooms throughout the facility for power strips and found no additional negative findings.  What measures will be put in place and what avertenian.	in  I e the ms ds. con  the e e e d all or	07/10/2025
					place and what systemic changes will be made to ensure that the deficient practice does not recur?		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155274	B. WI	NG		06/17/2025	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
			_		WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, THE	Ξ	ROCKF	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUGERIC N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG CROSS-RE		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
					On 7/2/2025 the administrator		
					inserviced the maintenance		
					supervisor/designee/all other	etaff	
					that power strips are not to be		
					used as a substitute for fixed		
					wiring to meet set standards.		
					The maintenance		
					supervisor/designee will inspe	ot all	
					rooms throughout the facility of		
					monthly basis to ensure they		
					not have power strips in use a		
					part of the facility's preventativ		
					maintenance program and	/E	
						oulto.	
					document those inspection res		
					as appropriate. If any issues a		
					discovered, they will be addre		
					and resolved immediately. The		
					maintenance supervisor/desig		
					will review with the administra	tor	
					the inspection results.		
					The administrator will monitor		
					adherence to the preventative		
					maintenance schedule and		
					validate the preventative		
					maintenance documentation is	s in	
					place.		
					Have the course still a setime (a)		
					How the corrective action(s)	ula a	
					will be monitored to ensure t	.116	
					deficient practice will not		
					recur, i.e., what quality	4	
					assurance program will be p	ut	
					into place?		
					The inspection results will be		
					presented by the maintenance	)	
					director/designee to the		
					administrator monthly and the		
					administrator will present the		
1					inspection results at the month	าly	

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QAPI meeting. Inspection results

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 155274 B. WING 06/17/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 815 W WASHINGTON ST WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE ROCKPORT, IN 47635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE and system components will be reviewed by the QAPI committee with subsequent plans of corrections developed and implemented as deemed necessary to ensure compliance is maintained. By what date the systemic changes for each deficiency will be completed? 7/10/2025 K 0921 **NFPA 101** SS=F Electrical Equipment - Testing and Bldg. 01 Maintenanc Based on record review, observation, and K 0921 It is the intent of the facility to 07/10/2025 interview, the facility failed to conduct the conduct the required maintenance required maintenance and maintain complete and maintain complete documentation of inspections for Patient Care documentation of inspection for Related Electrical Equipment (PCREE). NFPA 99 patient care related electrical 2012 edition, sections 10.3 and 10.5 states the equipment to meet set standards. physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE What corrective action(s) will is performed as required in 10.3. Testing intervals be accomplished for those are established with policies and protocols. All residents found to have been PCREE used in patient care rooms is tested in affected by the deficient accordance with 10.3.5.4 or 10.3.6 before being put practice? into service and after any repair or modification. On 7/8/2025 the facility's trained Any system consisting of several electrical regional property manager will appliances demonstrates compliance with NFPA conduct PCREE testing on

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99 as a complete system. Service manuals,

instructions, and procedures provided by the

manufacturer include information as required by

10.5.3.1.1 and are considered in the development

of a program for electrical equipment maintenance.

Electrical equipment instructions and maintenance

manuals are readily available, and safety labels

and condensed operating instructions on the appliance are legible. A record of electrical

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PCREE in the facility including

machines, and other electrical

standards. The administrator will

How other residents having the

medical equipment to meet

verify the work on 7/8/2025.

concentrators, vital sign

electric beds, nebulizers, oxygen

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155274	B. W	ING		06/17/	2025
				_	_		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
			_		WASHINGTON ST		
WATERS	S OF ROCKPORT	SKILLED NURSING FACILITY, THI	E	ROCKE	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE	DATE
	equipment tests, re	pairs, and modifications is			potential to be affected by th	ie	
	maintained for a pe	eriod of time to demonstrate			same deficient practice will I		
	compliance in acco	ordance with the facility's			identified and what corrective		
	policy. Personnel	responsible for the testing,			action(s) will be taken?		
	maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents.				All residents and staff and visi	itors	
					have the potential to be affect	ed	
					but none were.		
	Findings include:				What measures will be put in	nto	
					place and what systemic		
	Based on record re	view on 06/17/25 at 11:10 a.m.			changes will be made to		
	with the Administrator and Maintenance Director				ensure that the deficient		
	present, there was	no documentation for the			practice does not recur?		
	testing of PCREE, such as electric beds,				On 7/2/2025 the administrator		
	nebulizers, oxygen	concentrators, air pumps for air			inserviced the maintenance		
	mattresses, and oth	er electrical medical			supervisor/ designee/DON on		
	equipment. Based	on interview at 11:10 a.m.			requirements for all PCREE to	)	
	during record revie	w, the Administrator said she			meet set standards.		
	just found out abou	at the requirement and has not			Maintenance supervisor/desig	nee	
	tested and docume	nted the PCREE items yet.			will ensure testing of PCREE	is	
	Based on observati	ons between 12:40 p.m. and			conducted and documented o	n all	
	3:15 p.m. during a	tour of the facility with the			PCREE as part of the facility's	;	
	Administrator and	Maintenance Director it was			annual preventive maintenand	e	
	revealed the facility	y provided PCREE such as			program and document those		
		en concentrators, air pumps for			inspection results as appropri	ate.	
	1	other electrical medical			If any issues are discovered, t	they	
	equipment was pre	sent in the facility.			will be addressed and resolve	d	
					immediately. The maintenanc	e	
		eviewed with the Administrator			supervisor/designee will revie	W	
		Director during the exit			with the administrator the resu	ılts	
	conference.				of the inspection.		
					The administrator will monitor		
	3.1-19(b)				adherence to the preventative	:	
					maintenance schedule and		
					validate the preventative		
					maintenance documentation i	s in	
					place.		
					How the corrective action(s)		
					will be monitored to ensure	the	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  06/17/2025
	PROVIDER OR SUPPLIEF	SKILLED NURSING FACILITY, TH	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice will not recur, i.e., what quality assurance program will be pinto place?  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 QAPI meeting. Inspection results and system components will be reviewed by the QAPI commit with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.  By what date the systemic changes for each deficiency will be completed?  7/10/2025	e  hly ults oe ttee
K 0923 SS=E Bldg. 01	Based on observation failed to ensure cyling such as oxygen were in 1 of 1 oxygen storages. Health Care Factors 11.3.3 state gases with a total very greater than 8.5 cub comply with 11.3.3 Section 11.3.3.2 state cylinders specified accordance with 11	Cylinder and Container on and interview, the facility inders of nonflammable gases re properly secured from falling orage/transfilling room. NFPA cilities Code, 2012 Edition, res storage for nonflammable olume equal to or less than one meters (300 cubic feet) shall .1 and 11.3.3.2. NFPA 99, tes precautions in handling in 11.3.3.1 shall be in .6.2. Section 11.6.2.3(11) states ers shall be properly chained	K 0923	It is the intent of the facility to ensure cylinders of nonflamm gases such as oxygen are properly secured from falling oxygen storage/transfilling root to meet set standards.  What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice?  On 6/18/2025 the maintenance	in oms II n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155274 B. WING 06/17/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 815 W WASHINGTON ST WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE ROCKPORT, IN 47635 (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 or supported in a proper cylinder stand or cart. supervisor/DON/designee secured This deficient practice could affect mostly staff the 2 small "e" sized oxygen because the West Unit is currently closed to cylinders in the oxygen residents, except 1 or 2 residents while using the storage/transfilling room to meet Therapy gym. set standards. The administrator verified the work on 6/18/2025. Findings include: How other residents having the Based on observation on 06/17/25 at 12:25 p.m. potential to be affected by the during a tour of the facility with the Administrator same deficient practice will be and Maintenance Director, there were two small identified and what corrective "E" sized oxygen cylinders freestanding on the action(s) will be taken? floor in oxygen storage/transfilling room. Both All residents, staff and visitors oxygen cylinders were not supported in a proper have the potential to be affected cylinder stand or otherwise secured from falling. but none were. Based on interview at 12:25 p.m., the Maintenance Director acknowledged the two oxygen cylinders What measures will be put into freestanding on the floor and not supported in a place and what systemic cylinder stand or otherwise secured from falling. changes will be made to ensure that the deficient This finding was reviewed with the Administrator practice does not recur? and Maintenance Director during the exit On 7/2/2025 the administrator conference. inserviced the maintenance staff/DON/nursing staff on the 3.1-19(b) requirement to properly store and handle oxygen including properly securing the oxygen containers to meet set standards. The maintenance supervisor/DON/nursing staff will ensure to properly store and handle oxygen as part of the facility's oxygen polices, procedures, and inspections 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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C  O1	COMPLETED 06/17/2025
	PROVIDER OR SUPPLIED	R SKILLED NURSING FACILITY, TH	815 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST PORT, IN 47635	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				the inspection results. The administrator will monitor adherence to the preventative maintenance schedule and validate the preventative maintenance documentation is place.	in
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place?	
				The inspection results will be presented by the maintenance director/designee/DON to the administrator monthly and the administrator will present the inspection results at the monthly and the inspection results at the monthly at the inspection results at the monthly and the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the monthly at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspection results at the inspec	
				QAPI meeting. Inspection result and system components will be reviewed by the QAPI committed with subsequent plans of corrections developed and implemented as deemed necessary to ensure compliance is maintained.	ee
				By what date the systemic changes for each deficiency will be completed? 7/10/2025	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment -	Transfilling Cylinders			
	failed to ensure 1 o	on and interview, the facility f 1 oxygen storage room where takes place, was provided with	K 0927	It is the intent of the facility to ensure the oxygen storage roor where the oxygen transfilling ta	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155274	B. W	ING		06/17/2025	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R					
VA/A TED		SKILLED NUIDOING EAGULTY THE	_		WASHINGTON ST		
WATERS	OF ROCKPORTS	SKILLED NURSING FACILITY, THE		RUCKE	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	properly maintaine	d mechanical ventilation. This			place is provided with properly	v	
	deficient practice c	ould affect mostly staff			maintained mechanical ventila		
	because the West U	Unit is currently closed to			to meet set standards.		
	residents, except 1 or 2 residents while using the Therapy gym.						
					What corrective action(s) wil	iI e	
					be accomplished for those		
	Findings include:  Based on observation on 06/17/25 at 12:26 p.m. during a tour of the facility with the Administrator				residents found to have been	n	
					affected by the deficient		
					practice?		
					On 6/20/2025 the maintenanc	e	
	and Maintenance D	Director, the oxygen			supervisor replaced the		
	storage/transfilling	room was equipped with a			mechanically vented exhaust	fan	
	mechanically vented exhaust fan, however, it was				in the oxygen storage/transfilli		
	covered with dirt/d	ust at the time of observation.			room to meet set standards. T	·	
	Based on interview	at the time of observation, the			administrator verified the work	con	
	Maintenance Direc	tor agreed the mechanically			6/20/2025.		
	vented exhaust fan	was covered with dirt/dust.					
					How other residents having	the	
	This finding was re	eviewed with the Administrator			potential to be affected by th		
	and Maintenance D	Director during the exit			same deficient practice will b	ре	
	conference.				identified and what correctiv	'e	
					action(s) will be taken?		
	3.1-19(b)				All residents, staff and visitors	;	
					have the potential to be affect	ed	
					but none were.		
					What measures will be put in	nto	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					On 7/2/2025 the administrator		
					inserviced the maintenance		
					supervisor to ensure vented		
					exhaust fans are clean and fre	e of	
					dust/dirt to meet standards. The	ne	
					maintenance supervisor will		
					ensure vented exhaust fans a	re	
					clean and free of dust/dirt as p	part	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	CONSTRUCTION (X3) DAT		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155274	B. WI			06/17/	
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP COD		
			_		WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, THE	Ξ	ROCKE	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					of the facility's oxygen policy a	nd	
					procedures and document tho		
					inspection results as appropria		
					If any issues are discovered, t		
					will be addressed and resolve	-	
					immediately. The maintenance		
					supervisor/designee will review		
					with the administrator the	IV.	
					inspection results.  The administrator will monitor		
					adherence to the preventative		
					maintenance schedule and		
					validate the preventative		
					maintenance documentation is	3 IN	
					place.		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					The inspection results will be		
					presented by the maintenance	7	
					director/designee/DON to the		
					administrator monthly and the		
					administrator will present the		
					inspection results at the month	alv	
					QAPI meeting. Inspection resu	-	
					and system components will b		
					· · · · · · · · · · · · · · · · · · ·		
					reviewed by the QAPI commit	ree	
					with subsequent plans of		
					corrections developed and		
					implemented as deemed		
					necessary to ensure complian	ce	
					is maintained.		
					By what data the systemic		
					By what date the systemic		
					changes for each deficiency		
	l		1		will be completed?		I

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STATEMENT OF DEFIC	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORREC	N OF CORRECTION IDENTIFICATION NUMBER		a. building <u>01</u>		COMPLETED		
	155274		B. WING		06/17/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE				STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EAC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	C. OH CORRESPONDED LOWER CONTRACT P. D.C.		COMPLETION
TAG REGU	LATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					7/10/2025		

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