STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SI COMPLE 07/25/2			ETED	
	ROVIDER OR SUPPLIER S OF WABASH SKIL	LED NURSING FACILITY EAST 1	ГНЕ	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the Indaccordance with 42 Survey Date: 07/25 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I Waters of Wabash S was found not in condependent of the preparedness Required the preparedness Required to the prepared to the prep	20006 55006 290220 Preparedness survey, The Skilled Nursing Facility East impliance with Emergency rements for Medicare and fing Providers and Suppliers, 42 cility has a capacity of 84 and it the time of this survey.	E 00	000	Preparation and/or execution of this plan of correction in gener or this corrective action in particular does not constitute a admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The plan of correction constitutes of credible allegation of compliance with all regulatory requirement Our date of compliance is Aug 9, 2023. This provider respective requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a dereview in lieu of a post survey review.	de sis our oce os. ust fully f	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 §460.84(d)(2), §48 §483.475(d)(2), §4 (2), §491.12(d)(2),	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)					

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

(X6) DATE

TITLE

Michael Wolfe Administrator 08/11/2023

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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155006	B. W	ING		07/25/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ALBER ST		
WATERS	OF WABASH SKII	LLED NURSING FACILITY EAST	THE		SH, IN 46992		
(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	TF.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	OPO, "Organization	ons" under §485.727,					
	CMHCs at §485.9	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
		acility] must conduct					
		he emergency plan					
	I	ility] must do all of the					
	following:						
	(i) Dorticinata in a	full apple eversion that is					
	community-based	full-scale exercise that is					
	1	nunity-based exercise is					
		nduct a facility-based					
		e every 2 years; or					
		lity] experiences an actual					
	· , -	ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
	-	or individual, facility-based					
	1	e following the onset of the					
	actual event.	ŭ					
	(ii) Conduct an ad	ditional exercise at least					
	every 2 years, opp	posite the year the full-scale					
	or functional exerc	cise under paragraph (d)(2)					
	(i) of this section is	s conducted, that may					
	include, but is not	limited to the following:					
		scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
	· -	and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING		COMPI	LETED	
		155006	B. W	ING		07/25	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	₹			ALBER ST			
WATER	S OF WABASH SKI	LLED NURSING FACILITY EAS	T THE	WABAS	SH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COR		ECTION (X		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	the [facility's] eme	ergency plan, as needed.						
	*[For Hospices at	418.113(d):1						
	1 - '	espices that provide care in						
		e. The hospice must						
		s to test the emergency						
		ally. The hospice must do						
	the following:	, , , , , , , , , , , , , , , , , , , ,						
	_	a full-scale exercise that is						
	community based							
	_	nunity based exercise is not						
	1 ' '	ıct an individual facility						
		exercise every 2 years; or						
		experiences a natural or						
		ency that requires activation						
	_	plan, the hospital is						
		aging in its next required full						
		based exercise or individual						
		ctional exercise following the						
	onset of the emer	_						
		dditional exercise every 2						
	1 ' '	e year the full-scale or						
		e under paragraph (d)(2)(i)						
		conducted, that may						
		limited to the following:						
		-scale exercise that is						
	` '	or a facility based						
	functional exercise							
	(B) A mock disas	•						
	` '	ercise or workshop that is						
	1 ' '	and includes a group						
	discussion using a	- ·						
		emergency scenario, and a						
	set of problem sta	•						
	*	pared questions designed						
	to challenge an er							
	o Grandinge all el	morgonoy plan.						
	(3) Testing for hos	spices that provide inpatient						

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care directly. The hospice must conduct exercises to test the emergency plan twice

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 07/25/2023						
		PROVIDER OR SUPPLIER	LLED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP CO ALBER ST 6H, IN 46992)D	
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		per year. The hos (i) Participate in a that is community. (A) When a comm accessible, condu facility-based func (B) If the hospice of man-made emerg of the emergency exempt from enga full-scale commun functional exercise emergency event. (ii) Conduct an ac that may include, following: (A) A second full- community-based functional exercise (B) A mock disass (C) A tabletop exe facilitator that inclu using a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the h maintain documer exercises, and em the hospice's eme	spice must do the following: In annual full-scale exercise I-based; or In annual individual Itional exercise; or Iter drill; o					
		§482.15(d), CAHs (2) Testing. The [F conduct exercises plan twice per yea CAH] must do the	PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 07/25/2023					
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP COI ALBER ST SH, IN 46992)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF	JLD BE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that is community	-based; or					
	(A) When a comm	unity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund	tional exercise; or					
	(B) If the [PRTF, I	Hospital, CAH] experiences					
	an actual natural o	or man-made emergency					
	that requires activ	ation of the emergency					
		s exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
	ı •	t of the emergency event.					
	1 ' '	an [additional] annual					
		at may include, but is not					
	limited to the follo						
	1 ' '	scale exercise that is					
	community-based						
	facility-based fund	tional exercise; or					
	(B) A mo	ck disaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	nergency plan.					
	(iii) Analyze tl	ne [facility's] response to					
	and maintain docเ	umentation of all drills,					
	•	s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	, , =					
	` '	ACE organization must					
		to test the emergency					
	plan at least annu	-					
	organization must	_					
		ın annual full-scale exercise					
	that is community						
	1 ' '	nunity-based exercise is not					
1	accessible condu	ct an annual individual					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155006	B. W	ING		07/25	/2023
		l	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ALBER ST		
WATERS	S OF WARASH SKI	LLED NURSING FACILITY EAST	THF		SH, IN 46992		
	ı		1		, 10002		1
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ctional exercise; or					
	' '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	•	ngaging in its next required					
		nity based or individual,					
	onset of the emer	ctional exercise following the					
		n additional exercise every					
	, ,	the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited t						
		-scale exercise that is					
	` '	l or individual, a facility					
	based functional e						
	(B) A mock disas						
	' '	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an e						
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emerg	gency plan, as needed.					
	*[For LTC Facilitie	- , , -					
	· · · -	ity] must conduct exercises					
		ency plan at least twice per					
	, ,	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	_					
	. ,	an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not uct an annual individual,					
	facility-based fund						
	I racinty-based fulle	Alonai CACIOISC.	1				I

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 07/25/2023				ETED
	ROVIDER OR SUPPLIER	LLED NURSING FACILITY EAST	ГНЕ	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		
(X4) ID PREFIX		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ility] facility experiences an nan-made emergency that					
		n of the emergency plan, the					
		mpt from engaging its next					
	required a full-sca	lle community-based or					
	_	based functional exercise					
	_	et of the emergency event.					
	' '	dditional annual exercise					
	following:	but is not limited to the					
	•	scale exercise that is					
	, ,	or an individual, facility					
	based functional e	exercise; or					
	(B) A mock disas						
		ercise or workshop that is					
	led by a facilitator						
	discussion, using	a narrated, emergency scenario, and a					
	set of problem sta						
	•	pared questions designed					
	to challenge an er						
	(iii) Analyze the [l	LTC facility] facility's					
	response to and n	naintain documentation of					
	·	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
		CF/IID must conduct					
	exercises to test t	he emergency plan at least					
		e ICF/IID must do the					
	following:						
	(i) Participate in a that is community	n annual full-scale exercise					
	•	nunity-based exercise is not					
	` '	ict an annual individual,					
		ctional exercise; or.					
	•	experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the ICF/IID					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		A. BUILDING B. WING		COM	PLETED 25/2023
NAME OF F	PROVIDER OR SUPPLIER			r address, city, state, zip N ALBER ST	COD	
WATERS	S OF WABASH SKIL	LLED NURSING FACILITY EAST		ASH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	DRRECTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE
TAG		gaging in its next required	TAG			DATE
	1	ity-based or individual,				
		tional exercise following the				
	onset of the emerg	-				
	1	ditional annual exercise				
	that may include, I	out is not limited to the				
	following:					
	' '	scale exercise that is				
	community-based					
	facility-based func					
	(B) A mock disaste					
	1 ' '	rcise or workshop that is				
	1	and includes a group				
	discussion, using a	emergency scenario, and a				
	set of problem stat					
	1	pared questions designed				
	to challenge an en	-				
	_	F/IID's response to and				
	1 ' '	itation of all drills, tabletop				
		ergency events, and revise				
	the ICF/IID's emer	gency plan, as needed.				
	*[For HHAs at §48	-				
	1 ' '' '	e HHA must conduct				
		ne emergency plan at				
	1	e HHA must do the				
	following:	full coals aversion that in				
	(i) Participate in a community-based;	full-scale exercise that is				
	1	ommunity-based exercise				
	is not accessible,					
		pased functional exercise				
	every 2 years; or.	Table I allower at Short Short				
	1	A experiences an actual				
	1 ' '	ide emergency that requires				
		mergency plan, the HHA is				
		ging in its next required				
	full-scale commun	ity-based or individual,				
	facility based func	tional exercise following the				

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155006	l í	UILDING	nstruction 	COME	E SURVEY PLETED 5/2023
	OF PROVIDER OR SUPPLIE ERS OF WABASH SKI	R LLED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992	•	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	years, opposite the functional exercise of this section is continued, but is not (A) A second community-based facility-based funcially-based funcially-based funcially-based funcially-relevant set of problem star messages, or preto challenge an elevant is led by a facilitar discussion, using clinically-relevant set of problem star messages, or preto challenge an elevant in the HHA's emergent to challenge and elevant exercises, and entitle HHA's emergent to challenge and elevant in the HHA's emergent to challenge and elevant exercises to test to OPO must do the (i) Conduct a papor workshop at levant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing elevant emergency of the emergency	iditional exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may c limited to the following: full-scale exercise that is d or an individual, ctional exercise; or isaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETED B. WING 07/25/2023				LETED	
	PROVIDER OR SUPPLIEI S OF WABASH SKI	LLED NURSING FACILITY EAS	г тне	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		
(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)	ΛΤΕ	(X5) COMPLETION DATE
	exercises, and en the [RNHCl's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test to RNHCl must do the fill conduct a paper at least annually. Group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enthe RNHCl's eme Based on record refailed to conduct explan at least twice punannounced staff procedures. The LT following: (i) Participate in an is community-based a. When a community conduct facility-based function b. If the LTC facility or man-made emergency per from engaging its man community-based of the emergency per from engaging its man community-based of the conset of the activation of the activation of the conset of the activation	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a v-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency TC facility must do the annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based I exercise for I year following	E 0	039	1. CORRECTIVE ACTION TAKEN: a. On _08/09/2023 the Administrator and the Maintenance Supervisor/design conducted a community or facility-based annual exercise completed documentation for exercise to meet set standard 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTI a. All residents and all start and visitors have the potential be affected but none were. 3. MEASURES TO PREVIOUS REOCCURRENCE: a. On _08/09/2023 the Administrator inserviced the Maintenance Supervisor/design the requirement that a	gnee and the s. ED: ff I to	08/09/2023

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

PRINTED: 08/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. Bl	JILDING			COMPLETED	
		155006	B. W	ING		07/25/	2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t			ALBER ST			
WATERS	S OF WABASH SKII	LLED NURSING FACILITY EAST	ГНЕ		SH, IN 46992			
			· ·-			ı		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	a. A second full-sca				community or facility-based			
	•	r an individual, facility-based			exercise must be conducted			
	functional exercise.				annually and documentation			
	b. A mock disaster				retained to meet set standards	S.		
	_	se or workshop that is led by a			b. Maintenance			
		des a group discussion, using			Supervisor/designee will work	with		
		y-relevant emergency scenario,			the Administrator to ensure a			
	•	n statements, directed			community or facility-based			
		red questions designed to			exercise is conducted and			
	challenge an emerge				documented to meet set			
		C facility's response to and			standards. If any issues are			
		ation of all drills, tabletop			discovered, they will be addre	ssed		
		gency events, and revise the			and resolved immediately.			
		gency plan, as needed in			c. The Administrator will			
		CFR 483.73(d)(2). This			monitor adherence to the			
	deficient practice co	ould affect all occupants.			Emergency Preparedness Pol	icy		
					Manual and validate the			
	Findings include:				documentation is in place.			
					4. MONITORING			
		view and interview with the			CORRECTIVE ACTION:			
		he Maintenance Tech (MT)			a. At least annually to ens			
		p.m., no documentation of a			compliance, the Administrator			
		r facility based annual exercise			Maintenance Supervisor/desig	gnee		
		view. Based on interview at the			will review the Emergency			
		ew, the ED stated the facility			Preparedness Policy Manual a			
		n a full-scale exercise that is			conduct required exercises an			
		or a facility based exercise			make changes as necessary t	О		
	within the last 12 m	onths.			meet set standards. Those			
					reviews will be documented as			
	_	viewed with the Administrator			appropriate. The Administrato			
	and MT at the exit of	conference.			present the training results at			
					Quality Assurance/ Performan			
	3.1-19(b)				Improvement (QA/PI) meeting			
					Results and system compone	nts		
					will be reviewed by the QA/PI			
					Committee with subsequent p	lans		
					of correction developed and			
					implemented as deemed			
					necessary to ensure complian	ce		
					is maintained.			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/25/2023	
	PROVIDER OR SUPPLIER	LED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is _08/09/2023		(X5) COMPLETION DATE	
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/25 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety (Wabash Skilled Numot in compliance w Participation in Med Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type V111 construct The facility has a findetection in the corr corridors and in the facility has a capaci 39 at the time of this	200006 55006 90220 Code survey, The Waters of rsing Facility East was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and ty was determined to be of ction and was fully sprinklered. The ealarm system with smoke ridors, areas open to the resident sleeping rooms. The ty of 84 and had a census of	K 0	000	Preparation and/or execution this plan of correction in gene or this corrective action in particular does not constitute admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepare and/or executed in compliance with state and federal laws. The plan of correction constitutes credible allegation of compliance with all regulatory requirement Our date of compliance is Aug 9, 2023. This provider respect requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a direview in lieu of a post survey review.	ral, an is e c d e nis our nce ts. gust fully f f eesk		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/25/2023		
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0100 SS=E Bldg. 01	access were sprinkle facility services were Quality Review com NFPA 101 General Requirem General Requirem List in the REMAR Section 18.1 and	nents - Other RKS section any LSC 19.1 General Requirements					
	K-tags, but are de along with the app NFPA standard cit on Form CMS-256 Based on observation failed to maintain lass smoke barrier door requires existing lift the public if not requiter maintained or	ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included 67. on and interview, the facility atching hardware on 1 of 1 to the Dining hall. LSC 4.6.12.3 to safety features obvious to uired by the Code, shall be a removed. This deficient t staff and up to 30 residents	К (0100	1. CORRECTIVE ACTION TAKEN: a. On _07/25/2023 the Maintenance Supervisor/design made repairs to the latching hardware on the set of smoke barrier doors to the Dining Halensure it fully closes and latch into the frame to meet set standards. The Administrator verified the work on _07/25/20	gnee II to les	07/25/2023
	(MT) on 07/25/23 a barrier doors to the latching hardware b latch when tested. E of observation, the latch were equipped with doors did not proper	on with the Maintenance Tech t 02:10 p.m., the set of smoke Dining hall was provided with out failed to fully close and Based on interview at the time MT agreed the smoke doors latching devices, but the rly latch when tested.			2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staf and visitors have the potential be affected but none were. Or 07/25/2023 the Maintenanc Supervisor/designee inspected corridor doors throughout the facility and found no other neg findings. 3. MEASURES TO PREVE REOCCURRENCE: a. On 07/25/2023 the	ED: ff to n e d all gative	

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	OF CORRECTION	IDENTIFICATION NUMBER 155006	A. BUILDING B. WING	01	COMPLETED 07/25/2023				
	ROVIDER OR SUPPLIER	LED NURSING FACILITY EAST 1	STREET ADDRESS, CITY, STATE, ZIP COD 1900 N ALBER ST TTHE WABASH, IN 46992						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE				
				Administrator inserviced the Maintenance Supervisor/design on the requirement that corridors must fully self close and latch into the frame to meet sets standards. b. Maintenance Supervisor/designee will insperall corridor doors throughout the facility monthly to ensure they fully self close and latch into the frame as a part of the facility's Preventive 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. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results when the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed the OA/PI Committee with	or o				

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	R MEDICARE & MEDIC						B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		-
	OF CORRECTION	IDENTIFICATION NUMBER 155006	î ´	UILDING	01	COMPL 07/25/	ETED	
	PROVIDER OR SUPPLIER	LLED NURSING FACILITY EAS	г тне	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992			-
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	-
K 0291	NFPA 101				subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 07/25/2023.	s		
SS=E Bldg. 01	Emergency Lightin Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records refailed to ensure 6 or lights were tested in annually for 90 min requires functional monthly, with a min maximum of 5 weethan 30 seconds, (3 conducted annually if the emergency light powered and (5) Winspections and test for inspection by the	rig of at least 1-1/2-hour ed automatically in 7.9. Eview and interview, the facility of 6 battery backup emergency nonthly for 30 seconds and outes. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less of Functional testing shall be for a minimum of 1 1/2 hours ghting system is battery ritten records of visual as shall be kept by the owner e authority having efficient practice could affect all	K	291	1.CORRECTIVE ACTIONS TAKEN: 1.On _08/04/2023 _ the Maintenance Supervisor/desig conducted the monthly and an testing for the battery backup emergency lights and docume the results on the Battery-Operated Emergency Lights and signs Test Log to m set standards. The Administra verified the work on _08/04/20 2.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all state	nual nted neet ator 23	08/04/2023	
	Findings include:				and visitors have the potential			

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Based on records review with the Maintenance

and monthly testing for the battery backup

Director (MD) on 07/25/23 at 11:25 a.m., annual

emergency lights for 2023 was unavailable. The

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REOCCURRENCE:

be affected but none were.

Administrator inserviced the

3.MEASURES TO PREVENT

1.On <u>07/25/2023</u> the

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	OF CORRECTION	IDENTIFICATION NUMBER 155006		JILDING	01	COMPL 07/25/	ETED
	PROVIDER OR SUPPLIER	LED NURSING FACILITY EAST	ТНЕ	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	indicated the last an six battery backup e conducted in Januar at the time of record Director stated the r 90 minute testing fo emergency lights ha	nergency Light Test Log nual 90 minute testing for the mergency lights was y of 2022. Based on interview Is review, the Maintenance nonthly 30 second and annual r the six battery backup s not been conducted in 2023. The reviewed with the MD at the exit conference.			Maintenance Supervisor/design on the requirement to provide maintain emergency lighting a conduct the monthly and annutesting and document the result on meet set standards. 2.Maintenance Supervisor/designee will ensure provide and maintain emerger lighting and conduct the month and annual testing as a part of facility's Preventive Maintenant Program and document those tests on the Battery-Operated Emergency Lights and signs Toug and will maintain emerger lighting to meet set standards. any issues are discovered, the will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIACTION: 1. The inspection results will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system Inspection Inspecti	and nd ral all states of the control	

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STATEME?	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	<u>01</u>	COMPLETED 07/25/2023			
		155006	B. W	ING					
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1900 N ALBER ST						
WATERS	S OF WABASH SKI	LLED NURSING FACILITY EAS	ГТНЕ	WABA	SH, IN 46992				
(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 APPROPRIAT	Έ	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
					components will be reviewed b	y			
					the QA/PI Committee with				
					subsequent plans of correction				
					developed and implemented a	S			
					deemed necessary to ensure				
					compliance is maintained.				
					This plan of correction				
					constitutes our credible allegation of compliance with				
					all regulatory requirements.				
					Our date of compliance is				
					_08/04/2023				
					<u> </u>				
K 0300	NFPA 101								
SS=E	Protection - Other								
Bldg. 01	Protection - Other								
	List in the REMAR	RKS section any LSC							
	Section 18.3 and	19.3 Protection							
	requirements that	are not addressed by the							
	provided K-tags, I	out are deficient. This							
	information, along	with the applicable Life							
	Safety Code or N	FPA standard citation,							
		d on Form CMS-2567.							
		view and interview, the facility	K 0	300	1) CORRECTIVE ACTIONS	;	07/26/2023		
	failed to ensure doc				TAKEN:				
	_	enance of battery operated			a) On <u>07/26/23</u> the				
		rious rooms was complete.			Maintenance Supervisor/desig				
		2.3 states existing life safety			replaced batteries in the currer				
		the public, if not required by			smoke alarms and documente	d on			
	· ·	maintained. NFPA 72, 29.10			the Battery-Operated Smoke				
		ests. Fire-warning equipment			Detector Maintenance Log to r				
		and tested in accordance with			set standards. The Administra				
		published instructions and per			verified the work on <u>07/26/20</u>	23_			
	_	Chapter 14. NFPA 72,							
	_	on, testing, and maintenance			2) ALL OTHERS WITH	:D:			
	T DEOPTAINS SHAD SAM	SEVENCE LEGITLE CHIEFILS OF LITTS			I ECTENTIAL TO BE AFFECTE		1		

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staff.

Code and conform to the equipment

manufacturer's published instructions. This

deficient practice could affect 10 residents and 10

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All residents and all staff

MEASURES TO PREVENT

and visitors have the potential to

be affected but none were.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED.
		155006	B. W	ING		07/25/	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			ALBER ST		
WATERS	OF WABASH SKI	LLED NURSING FACILITY EAST	ТНЕ		SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					REOCCURRENCE:		
	Findings include:				a) On <u>07/25/2023</u> the		
					Administrator inserviced the		
		eview with the Maintenance			Maintenance Supervisor/desig	-	
		07/25/23 at 11:15 a.m., no			on the requirement that batter	-	
	_	pattery replacement of battery			operated smoke alarms must		
	-	rms was available for review.			tested monthly, maintained ar		
		at the time of review, the			documentation retained at the)	
		tor stated the smoke alarms are			facility to meet set standards.		
	•	did not know when the			b) Maintenance		
	batteries were last of	changed.			Supervisor/designee will cond		
					testing on all battery-operated	J	
	_	viewed with the Administrator			smoke detectors per		
	and MD at the exit	conference.			manufacturer's guidelines		
	2.4.40(1)				throughout the facility and		
	3.1-19(b)				document the results on the		
					Battery-Operated Smoke Dete		
					Maintenance Log to be filed in		
					Life Safety Binder as a part of	the	
					facility's monthly Preventive		
					Maintenance Program. If any		
					issues are discovered, they w	III be	
					addressed and resolved		
					immediately. The Maintenand		
					Supervisor/designee will revie	·W	
					with the Administrator the		
					inspection results.		
					c) The Administrator will monitor adherence to the		
					Preventative Maintenance		
			1		schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4) MONITORING		
					CORRECTIVE ACTION:		
					a) The inspection results v	will	
			1		be presented by the Maintena		
					Supervisor/designee to the	1100	
					Administrator monthly and the	۷	
			1		Administrator will present the		
	İ		1		1a.i ator will prodotit tile		1

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155006		A. BUILDING B. WING	COMPLETED 07/25/2023	
	ROVIDER OR SUPPLIER OF WABASH SKIL	LED NURSING FACILITY EAST T	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Buil Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers shall be positive atrium wall. Smoke in duct penetration systems where an is installed for smoto the smoke barrier 19.3.7.3, 8.6.7.1(1) Describe any medisystem in REMAR	Iding Spaces - Smoke Iding Spa		inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is	nly bee been been been been been been been
	failed to ensure pend barrier wall were pro- resistance of each sr 19.3.7.5 requires sm	on and interview, the facility etrations through 1 of 1 smoke otected to maintain the smoke moke barrier. LSC Section toke barriers to be constructed LSC Section 8.5 and shall have	K 0372	CORRECTIVE ACTIONS TAKEN: a. On 07/25/2023 the Maintenance Supervisor/designsealed the gap around a pipe of a one hour fire rated material to the second	nee

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	BUILDING	01	COMPL	LETED
		155006	B. V	VING		07/25	/2023
	1	LLED NURSING FACILITY EAST STATEMENT OF DEFICIENCIE	THE	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992 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
	Section 8.5.2.1 requestion and similar items to a smoke barrier, thereof. 8.5.6.2 requable trays, conduit and similar items to mechanical, plumbs systems that pass the floor/ceiling assembarrier, or through roof/ceiling of a smarrier, or through roof/ceiling of a smarrier items to make the move practice could affect in two smoke comparative could affect in two smoke comparative (MT) on 07/25/23 a ceiling of the smoke there was a gap around at the time of observation was a 2 inch x 3 incompipe penetrating the The finding was revenue.	fire resistive rating. LSC usines smoke barriers to be outside wall to an outside of a floor, or from a smoke barrier or by use of a combination quires penetrations for cables, is, pipes, tubes, vents, wires, of accommodate electrical, ing, and communications arough a wall, floor, or obly constructed as a smoke the ceiling membrane of the moke barrier assembly, shall be earn or material capable of cement of smoke. This deficient out staff and at least 30 residents out that the Maintenance Tech at 02:40 p.m., above the drop wall in the 300-hall smoke wall und a pipe. Based on interview vation, the MT agreed there when unsealed penetration below a ce 200-hall smoke barrier. Wiewed with the MT, and the ang the exit conference.			was noted above the drop cei of the smoke wall in the 300 h smoke wall to meet set standards. The Administrator verified the repairs on 07/25/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta and visitors have the potential be affected but none were. O 07/25/2023 the Maintenanc Supervisor/designee inspecte ceiling smoke barriers through the facility for penetrations an found no other negative finding. 3. MEASURES TO PREVINGE a. On 07/25/2023 the Administrator inserviced the Maintenance Supervisor/designee inspectes on the requirement that ceiling smoke barriers must be maintained and must be free of penetrations to meet set standards. b. Maintenance Supervisor/designee will inspect all ceiling smoke barriers and ensure they are maintained and free of penetrations as a part the facility's monthly Preventing Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addresing and resolved immediately. The Maintenance Supervisor/designee will inspect and resolved immediately. The Maintenance Supervisor/designee will inspect and resolved immediately. The Maintenance Supervisor/designee will be addresing and resolved immediately. The Maintenance Supervisor/designee will inspect and resolved immediately. The Maintenance Supervisor/designee will be addresing and resolved immediately. The Maintenance Supervisor/designee will inspect and resolved immediately.	ED: Iff I to on ce ed all nout days. ENT gnee g of ect nd of ve sults are essed ane gnee	
	1				will review with the Administra	ποι	1

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the inspection results.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155006	A. B	MULTIPLE CO FUILDING VING	onstruction 01	COMI	e survey pleted 5/2023
	ROVIDER OR SUPPLIER	LLED NURSING FACILITY EAST	THE	1900 N	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION ILD BE ROPRIATE	(X5) COMPLETION DATE
					c. The Administrator of monitor adherence to the Preventative Maintenanch schedule and validate the Preventative Maintenanch documentation is in place 4. MONITORING CORRECTIVE ACTION: a. The inspection results action results are the presented by the Main Supervisor/designee to the Administrator monthly an Administrator will present inspection results at their Quality Assurance/Perfor Improvement (QA/PI) mellinspection results and sy components will be reviet the QA/PI Committee with subsequent plans of correction developed and implement deemed necessary to encompliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance 07/25/2023.	e e e e e e e e e e e e e e e e e e e	
K 0500 SS=E Bldg. 01	Section 18.5 and requirements that provided K-tags, binformation, along Safety Code or NF						

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CENTERS FOR MEDICARE & MEDICAID SERVICES								OM	B NO. 0938-039
	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CO	ONSTRUCTION	(X3) DATE	SURVEY
	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDIN	lG	01	COMPL	ETED
			155006	B. W	ING			07/25	/2023
_					_	-	_		
	NAME OF P	ROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD					
							ALBER ST		
	WATERS	OF WABASH SKII	LLED NURSING FACILITY EAST	ГНЕ	I WA	ABAS	SH, IN 46992		
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		DECLIDED IN AN OF CORRECTION		(X5)
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		COMPLETION
	TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAC	j	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		Based on observation	on and interview, the facility	K 0	500		1. CORRECTIVE ACTION	 S	08/09/2023
			f 5 fuel fired water heaters had	110	200		TAKEN:		00/07/2023
		current inspection c	ertificates to ensure the water				a. On <u>03/14/2023</u> a Cert	ified	
		-	operating condition. NFPA				Water Heater Inspector inspec		
			3.1 requires all health facilities				the two boilers in the mechanic		
			tructed, maintained and				room and provided the facility		
		-	ze the possibility of a fire				Certificates of Inspection to me		
		-	g the evacuation of occupants.				set standards. The Administra		
			ice could affect up to 10				verified the inspections and re-		
		residents in the med	-				of the documentation on		
							08/09/2023 .		
		Findings include:					2. ALL OTHERS WITH		
		8					POTENTAL TO BE AFFECTE	D.	
		Based on observation	on during a tour of the facility				a. All residents and all staf		
			ce Tech on 07/25/23 at 02:25				and visitors have the potential		
			rs in the mechanical room did				be affected but none were.		
		-	cumentation to show when				3. MEASURES TO PREVE	NT	
			pected. The two waters				REOCCURRENCE:		
			ection certificate with an				a. On <u>07/25/2023</u> the		
			05/21/23. Based on interview at				Administrator inserviced the		
		-	rvation, the Maintenance				Maintenance Supervisor/desig	inee	
			rent inspection for the two				on the requirement that fuel-fir		
			not be found and agreed the				water heaters must be inspect		
			pection was past due and				and a Certificate of Inspection		
		needed to be inspec	-				retained at the facility to meet	set	
		1					standards.		
		This finding was re	viewed with the Administrator				b. Maintenance		
			ech at the exit conference.				Supervisor/designee will check	k all	
							fuel-fired water heaters annual		
		3.1-19(b)					ensure they are inspected and	•	
		. /					documentation retained at the		
							facility as a part of the facility's		
							Preventive Maintenance Progr		
							and document those inspection		
							results as appropriate. If any		
							issues are discovered, they wi	ll be	
							addressed and resolved	50	
							immediately. The Maintenanc	e	
							Supervisor/designee will review		
				1			L Saber Algertaegidinee Mili Levier	**	I

with the Administrator the

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

PRINTED: 08/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLI	
		155006	B. W	ING		07/25/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ALBER ST		
WATERS	OF WABASH SKII	LED NURSING FACILITY EAST	THE	WABAS	SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING CORRECTIVE ACTION:		
					a. The inspection results w	,iII	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	ılv	
					Quality Assurance/Performand	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	эу	
					the QA/PI Committee with		
					subsequent plans of correction	ı	
					developed and implemented a	s	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	ו	
					all regulatory requirements.		
					Our date of compliance is		
					<u>08/09/2023</u> .		
K 0918	NFPA 101						
SS=F	_	- Essential Electric Syste					
Bldg. 01	-	s - Essential Electric					
Ĭ	System Maintenar						
	_ ·	other alternate power					
	_	ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					

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

Event ID:

K42021

Facility ID: 000006

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155006	l í	UILDING	onstruction 01	(X3) DATE COMPL 07/25 /	ETED	
	PROVIDER OR SUPPLIEI S OF WABASH SKI	LLED NURSING FACILITY EAST	STREET ADDRESS, CITY, STATE, ZIP COD 1900 N ALBER ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	safety and critical and testing of the switches are performed. NFPA 110. Generator sets are exercised under layear in 20-40 day once every 36 mc Scheduled test ura complete simula automatic or man loads, and are corpersonnel. Maintenergy power sou accordance with 10 circuit breakers are program for period components is estimated and readily availa and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1	(NFPA 99), NFPA 110, 0 (NFPA 70)	K O	018	1 CORRECTIVE ACTION	9	08/04/2023	
	failed to maintain 1 Standby System in Standard for Emerg Systems, Section 8 Health Care Facilit NFPA 110 Section Emergency Power load at least once w Where the assigned	of 1 Emergency Power accordance with NFPA 110, gency and Standby Power 4.9, as required by NFPA 99 ies Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested under within every three years. I class is greater than 4 hours, I to terminate the test after 4	K 0	918	1. CORRECTIVE ACTION TAKEN: a. On 08/04/2023 the Facilities Certified Contractor conducted the four hour load of for the emergency generator adocumented the results to me set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTIAL. a. All residents and all stars.	est and et ED:	08/04/2023	

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

Event ID:

K42021

Facility ID: 000006

If continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	_		01	COMPLETED			
155006		B. WING			07/25/2023				
NAME OF T	ADOLUDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	t .		1900 N	ALBER ST				
WATERS OF WABASH SKILLED NURSING FACILITY EAST T									
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY 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 OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE		
		ection 6.4.1.1.6.1 states that			and visitors have the potential	to			
	Type 1 and Type 2 essential electrical system				be affected but none were.				
	power sources shall be classified at Type 10,				3. MEASURES TO PREVE	ENT			
	Class X, Level 1 generator sets. This deficient			REOCCURRENCE:					
	practice could affect all building occupants.				a. On <u>07/25/2023</u> the				
					Administrator inserviced the				
	Findings include:				Maintenance Supervisor/designee				
					on the requirement that a four	hour			
	During records review with the Maintenance				load test on the emergency				
		7/25/23 at 10:50 a.m.,			generator must be conducted				
	documentation of a four hour load test for the				once every three years and				
	emergency generator conducted within the last 36				documented to meet set				
	months was not provided for review. Based on				standards.				
	interview at the time of records review, the				b. The Maintenance				
	Maintenance Director stated he did not know if a				Supervisor/designee will ensu				
	four hour continuous run under load was not				annual four hour load test on t				
	conducted in the past 36 months.				emergency generator is condu	ucted			
					once every three years and				
	This finding was reviewed with the Administrator				documented as a part of the				
	and Maintenance Director at the exit conference.				facility's Preventive Maintenar				
					Program and document those				
	3.1-19(b)				inspection results as appropria				
					If any issues are discovered, t	-			
					will be addressed and resolve				
					immediately. The Maintenand				
					Supervisor/designee will revie	W			
					with the Administrator the				
					inspection results.				
					c. The Administrator will				
					monitor adherence to the				
					Preventative Maintenance				
					schedule and validate the				
					Preventative Maintenance				
					documentation is in place.				
					2. MONITORING				
					CORRECTIVE ACTION:	•••			
					a. The inspection results w				
					be presented by the Maintena	nce			
					Supervisor/designee to the				
			1		Administrator monthly and the	!			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/14/2023
FORM APPROVED
OMB NO. 0938 039

CENTERS FOR	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 <u>01</u>			COMPLETED		
		155006	B. WING			07/25/2023		
WATERS	_	LLED NURSING FACILITY EAST 1	HE	1900 N WABAS	ADDRESS, CITY, STATE, ZIP COD ALBER ST SH, IN 46992		(V5)	
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX			ΤE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG				DATE	
					Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 08/04/2023.	ce		

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