STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPI	
		155274	B. W	ING		01/18	/2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	-	
WATERS	OF ROCKPORT S	SKILLED NURSING FACILITY, TH	E		WASHINGTON ST PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/18/23		E 00	000			
	Facility Number: 0 Provider Number: 1002	00174 155274					
	At this Emergency Preparedness survey, The Waters of Rockport Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73						
	the survey, the cens						
	Quality Review con	npleted on 01/25/23					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/18 Facility Number: 0 Provider Number: AIM Number: 1000	00174 155274	K 0	000			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	Ξ	TITLE		(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN LAURIE BARNETT				HFA			02/06/2023

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 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/18/2023	
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	STREET A 815 W N ROCKF		
(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
	compliance with Re Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This one story facilit Type V (000) constr sprinklered. The fact with hard wired smoth and spaces open to to operated smoke alar rooms. The facility census of 39 at the to All areas where the access were sprinkle facility services were detached structures, for a maintenance sli	residents have customary ered and all areas providing re sprinklered, except two a wood framed garage used mop and facility storage, as ned house used for facility			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required be equipped with a requires the use of egress side unless special locking arm CLINICAL NEEDS LOCKING Where special lock clinical security ne	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following			

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FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	1B NO. 0938-039	
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	COMPLETED		
		155274	B. W	ING			/2023	
		10027 1	5			01/10	72020	
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	- KOVIDEK OK SUFFLIEF			815 W \	WASHINGTON ST			
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, T	HE	ROCKP	PORT, IN 47635			
			1				715	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	permitted on each	n door and provisions shall						
	be made for the ra	apid removal of occupants						
	by: remote contro	l of locks; keying of all						
	locks or keys carr	ied by staff at all times; or						
	· ·	e means available to the						
	staff at all times.							
		.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6	.2.2.0, 10.2.2.2.0.1,						
	SPECIAL NEEDS	LOCKING						
	ARRANGEMENT							
		king arrangements for the						
	· ·	•						
		e patient are used, all of						
		curity Locking requirements						
		addition, the locks must be						
		at fail safely so as to						
		of power to the device; the						
		ed by a supervised						
	automatic sprinkle	er system and the locked						
		d by a complete smoke						
	detection system	(or is constantly monitored						
	at an attended loc	ation within the locked						
	space); and both	the sprinkler and detection						
	systems are arran	iged to unlock the doors						
	upon activation.							
	18.2.2.2.5.2, 19.2	.2.2.5.2. TIA 12-4						
	DELAYED-ÉGRE							
	ARRANGEMENT							
		lelayed-egress locking						
		in accordance with						
		permitted on door						
		ig low and ordinary hazard						
		•						
		ngs protected throughout by						
		ervised automatic fire						
	_	or an approved, supervised						
	automatic sprinkle	-						
	18.2.2.2.4, 19.2.2							
	ACCESS-CONTR	ROLLED EGRESS						
	LOCKING ARRAN	NGEMENTS						
	Access-Controlled	d Egress Door assemblies						

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installed in accordance with 7.2.1.6.2 shall

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155274 NAME OF PROVIDER OR SUPPLIER WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION Department of the permitted of the permitted be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS A. BUILDING D1 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635 (X5) PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OATER A. BUILDING D1 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635 (X5) COMPLETION DATE	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Department of Deficiency Date of Date of Deficiency Date of	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS 815 W WASHINGTON ST ROCKPORT, IN 47635 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 815 W WASHINGTON ST ROCKPORT, IN 47635			155274	B. W	ING		01/18/	2023
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS 815 W WASHINGTON ST ROCKPORT, IN 47635 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 815 W WASHINGTON ST ROCKPORT, IN 47635					STREET	ADDRESS CITY STATE ZIP COD		
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS ROCKPORT, IN 47635 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Deficiency A COMPLETION DATE (X5) COMPLETION DATE	NAME OF F	PROVIDER OR SUPPLIE	R					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE	WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY TI	4E				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION TAG PREFIX FROUGHCH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	WATERC	· · · · · · · · · · · · · · · · · · ·	SKIELED NOROING I ACIEITT, II	·-	ROOK			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX		ATE	COMPLETION
18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS	TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
ELEVATOR LOBBY EXIT ACCESS								
		18.2.2.2.4, 19.2.2	2.2.4					
LOCKING ARRANGEMENTS		ELEVATOR LOB	BY EXIT ACCESS					
Elevator lobby exit access door locking in		1	-					
accordance with 7.2.1.6.3 shall be permitted								
on door assemblies in buildings protected			• .					
throughout by an approved, supervised								
automatic fire detection system and an			-					
approved, supervised automatic sprinkler			ised automatic sprinkler					
system.		1						
18.2.2.2.4, 19.2.2.2.4								
		Based on observation and interview, the facility		K 0	222			02/06/2023
failed to ensure the means of egress through 9 of Preparation and/or execution						-	n	
9 exits was readily accessible for residents without of this plan of correction in		I						
a clinical diagnosis requiring specialized security general, or this corrective		_				<u> </u>		
measures. Doors within a required means of action, does not constitute an			-					
egress shall not be equipped with a latch or lock admission or agreement by this		_						
that requires the use of a tool or key from the facility of the facts alleged or		_				_		
egress side unless otherwise permitted by LSC conclusions set forth in this		_						
19.2.2.2.4. Door-locking arrangements shall be statement of deficiencies. The								
permitted in accordance with 19.2.2.2.5.2. This plan of correction and specific		_				1 -		
deficient practice could affect all residents staff corrective actions are prepared		•				1		
and visitors needing to exit the facility. and/or executed in compliance		and visitors needing	g to exit the facility.			·	ice	
with state and federal laws.		Eindings in stude.						
Findings include: This plan of correction		rindings include:				-	ion	
Based on observations on 01/18/23 between 12:10 constitutes a written allegation of substantial compliance with		Based on observati	ons on 01/18/23 between 12:10			_		
Based on observations on 01/18/23 between 12:10 of substantial compliance with p.m. and 2:30 p.m. during a tour of the facility with Federal Medicare and						<u> </u>	IUI	
the Maintenance Supervisor, all nine exit doors to Medicaid requirements.		_						
the outside were posted with the incorrect code to K222— It is the intent of the facility						<u>-</u>	cility	
actuate the door release. The Maintenance to ensure the means of egress							-	
Supervisor was able to open the door with the through exits is readily accessible								
correct code. Based on interview at the time of for residents without a clinical		_				_		
each observation, the Maintenance Supervisor diagnosis requiring specialized								
agreed the correct codes should be displayed on security measures to meet set								
the keypad at each exit door.						<u> </u>	٠	
1. CORRECTIVE ACTIONS		are keypad at each	Chit door.				ıs	
These findings were reviewed with the TAKEN:		These findings wer	re reviewed with the					
Administrator and Maintenance Supervisor a. On 01/18/2023, The		_						

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

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/18/2023
	PROVIDER OR SUPPLIES	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	during the exit contact 3.1-19(b)			Maintenance Supervisor/designosted information on how to obtain the code at all nine existed doors to meet set standards. Administrator verified the work on. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. On 1/18/2023, the Maintenance Supervisor/designee inspected doors to ensure information of how to obtain the codes was present and found no other negative findings. 3. MEASURES TO PREVINGE TO PREVINGE Administrator in-serviced the Maintenance Supervisor/designed and all other staff on the requirement that information obtain the codes must be posent at the exit doors to meet set standards. b. Maintenance Supervisor/designed will inspand all means of corridor doors to ensure they have information how to obtain the codes as a of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issued discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designed will review with the Administrator in the codes will review with the Administrator in the codes as a control of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issued discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designed will review with the Administrator with the Administrator in the codes will review with the Administrator in the codes and the facility's Preventive Maintenance Supervisor/designed will review with the Administrator in the codes and the facility is preventive with the Administrator in the codes and the facility is preventive with the Administrator in the codes and the facility is preventive with the Administrator in the codes and the facility is preventive with the Administrator in the codes and the facility is preventive with the Administrator in the codes and the facility is prevention.	ignee it The rk FED: aff al to On e ed all on FENT ignee to sted oect o n on part essults s are essed ihe ignee

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Event ID:

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

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/18/2023
	ROVIDER OR SUPPLIER	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 CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				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 be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performar Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wire all regulatory requirements. Our date of compliance is 02/06/2023.	e thly nce g. n by
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooki				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPI	
		155274	B. W.	ING		01/18/2023	
NAME OF	PROVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATER	S OF ROCKPORT S	SKILLED NURSING FACILITY, T	HE	ROCK	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	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
	· '	for food warming or limited					
	1	ance with 18.3.2.5.2,					
	19.3.2.5.2						
	_	open to the corridor in					
	•	ents with 30 or fewer					
	1	rith the conditions under					
	18.3.2.5.3, 19.3.2						
	_	in smoke compartments					
		atients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
	_	protected according to					
	•	3 are not required to be rdous areas, but shall not					
	be open to the co	•					
	1 '	1 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
	1	view and interview, the facility	K 0	324	K324– It is the intent of the fac	cility	02/06/2023
		f 1 kitchen exhaust systems	IX 0	<i>32</i> ¬	to ensure the kitchen exhaust	Jiirty	02/00/2023
		annually. NFPA 96, 2011			system is inspected		
	_	or Ventilation Control and Fire			semi-annually to meet set		
	1	nercial Cooking Operations,			standards.		
		the entire exhaust system shall			1. CORRECTIVE ACTIONS		
	be inspected for gre	ease buildup by a properly			TAKEN:		
	trained, qualified, a	nd certified person(s)			a. A Certified Contractor will		
	acceptable to the au	thority having jurisdiction			perform the range hood exhau	ıst	
		with Table 11.4. Table 11.4,			system inspection by 2/12/23	and	
	_	ction for Grease Buildup,			the results will be documented	l in	
		rving moderate volume			the facilitie's Life Safety Binde	r to	
	cooking operations	•			meet set standards. The		
		PA 96, 11.6.1 states, upon			Administrator will verify the w	ork	
	_	chaust system is found to be			on 2/12/23 .		
		deposits from grease laden			2. ALL OTHERS WITH		
	_	inated portions of the exhaust			POTENTIAL TO BE AFFECTE		
	1 -	aned by a properly trained,			a. All residents and all staff a		
	1 -	fied person(s) acceptable to the			visitors have the potential to b	е	
		risdiction. Hoods, grease			affected but none were. The		
	1	ns, ducts, and other			facility has only one kitchen.		
	appurtenances shall	be cleaned to remove	1		3. MEASURES TO PREVENT		1

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combustible contaminants prior to surfaces

becoming heavily contaminated with grease or

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REOCCURRENCE:

a. On 01/18/2023, the

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STATEMEN	T OF DEFICIENCIES	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	ING		01/18	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, THE	=		PORT, IN 47635		
WATERC	OI ROOKI OKI C	SKILLED NORGING LACILITY, THE		NOCKI			
(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
		he exhaust system is cleaned,			Administrator in-serviced the		
		d with powder or other			Maintenance Supervisor/desi	gnee	
		n exhaust cleaning service is			on the requirement that the		
	used, a certificate showing the name of the				kitchen exhaust system must l	be	
		the name of the person			maintained in proper working		
		k, and the date of inspection or			condition to meet set standard	ls.	
	~	aintained on the premises.			b. Maintenance		
	-	ice could affect mostly kitchen			Supervisor/designee will inspe	ect	
	-	ents while in the adjacent			the kitchen hood system mont	hly	
	dining room.				to ensure the kitchen exhaust		
					system is properly maintained		
	Findings include:				a part of the facility's Preventi	ve	
					Maintenance Program and		
		view on 01/18/23 between 9:30			document those inspection res	sults	
	_	. with the Maintenance			as appropriate. If any issues	are	
		the only inspection			discovered, they will be addre	ssed	
	documentation avai	lable during the past twelve			and resolved immediately. Th	ie	
	-	e hood exhaust system was			Maintenance Supervisor/desig	gnee	
		ere was no range hood exhaust			will review with the Administra	tor	
	system inspection r	eport available within six			the inspection results.		
		/15/22 date. Based on			c. The Administrator will moni	itor	
		e of record review, the			adherence to the Preventative	•	
	^	visor said the facility recently			Maintenance schedule and		
		to inspect the range hood			validate the Preventative		
	-	the new company has not yet			Maintenance documentation is	s in	
	inspected the range	hood.			place.		
					4. MONITORING CORRECTIV	/E	
		viewed with the Administrator			ACTION:		
		upervisor during the exit			a. The inspection results will b		
	conference.				presented by the Maintenance)	
					Supervisor/designee to the		
	3.1-19(b)				Administrator monthly and the	!	
					Administrator will present the		
					inspection results at the month	-	
					Quality Assurance/Performand		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	by	
					the QA/PI Committee with		
			I		subsequent plans of correction	^	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155274	B. WI	NG		01/18/	2023
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATERS	OF ROCKPORT S	KILLED NURSING FACILITY, THI		ROCKP	PORT, IN 47635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					developed and implemented a deemed necessary to ensure	S	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements.		
					Our date of compliance is		
					02/06/2023.		
K 0353	NFPA 101						
SS=E	Sprinkler System -	- Maintenance and Testing					
Bldg. 01	Sprinkler System -	- Maintenance and Testing					
	-	er and standpipe systems					
	•	ted, and maintained in					
		IFPA 25, Standard for the					
	•	g, and Maintaining of Protection Systems.					
		n design, maintenance,					
	-	ting are maintained in a					
		d readily available.					
		system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Dravida in DEMAE	 RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,	-					
		ation and interview, the	K 03	353	K353 – It is the intent of the		02/06/2023
	facility failed to ens	ure 1 of 1 fire department			facility to ensure fire departme	nt	
		ccordance with NFPA 25, 2011			connection is in accordance w		
		or the Inspection, Testing, and			NFPA 25, 2011 edition, Stand		
		ter-Based Fire Protection			for the Inspection, Testing, and		
		3.7.1 requires fire department			Maintenance of water-based fi		
		spected quarterly to verify			protection systems and to ens		
	the following: (1) The fire departm	nent connections are visible			the ceiling in sprinklered smok		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 01/18/2023 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 and accessible. allow sprinkler heads to function to (2) Couplings or swivels are not damaged and their full capability to meet set rotate smoothly. standards. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. 1.CORRECTIVE ACTIONS (5) Identification signs are in place. TAKEN: (6) The check valve is not leaking. 1.On 01/31/2023, a FDC (7) The automatic drain valve is in place and sign was ordered and will be operating properly. installed by 022823 by the (8) The fire department connection clapper(s) is in Maintenance Supervisor/designee place and operating properly. at the facilities fire department This deficient practice could affect all occupants. connection at the front side of the facility on the wall outside the Findings include: sprinkler riser room to meet set standards. The Administrator Based on observations on 01/18/23 between 12:10 verified the work on 01/31/2023. p.m. and 2:30 p.m. during a tour of the facility with 2. On 01/19/2023, a the Maintenance Supervisor, the facility's fire Maintenance Supervisor/designee department connection (FDC) was located at the repaired the three sprinkler front side of the facility on the wall outside the escutcheon rings in room 116 to sprinkler riser room. There was no FDC signage meet set standards. The provided near the fire department connection for Administrator verified the work on the responding fire department for easy 01/19/2023. identification. Based on interview at the time of 3.On 01/19/2023, a observation, this was acknowledged by the Maintenance Supervisor/designee Maintenance Supervisor who agreed there should installed the sprinkler escutcheon be FDC signage near the Fire Department ring in the west hall central Connection. bathroom to meet set standards. The Administrator verified the work This finding was reviewed with the Administrator on 01/19/2023.

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conference.

3.1-19(b)

and Maintenance Supervisor during the exit

2. Based on observation and interview, the

facility failed to ensure the ceiling in 2 of 7

sprinklered smoke compartments was maintained

to allow sprinkler heads to function to their full

capability. This deficient practice could affect at

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on 01/19/2023.

4.On 01/19/2023, a

ring in the middle entrance/exit short hall to meet set standards.

5. On 01/19/2023. a

Maintenance Supervisor/designee

repaired the sprinkler escutcheon

Maintenance Supervisor/designee repaired the sprinkler escutcheon

The Administrator verified the work

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02/10/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 B. WING 01/18/2023 155274 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 least 20 residents, staff, and visitors. ring in the middle back entrance/exit short hall to meet Findings include: set standards. The Administrator verified the work on 01/19/2023. Based on observations on 01/18/23 between 12:10 6.On 01/20/2023. a p.m. and 2:30 p.m. during a tour of the facility with Maintenance Supervisor/designee the Maintenance Supervisor, the following was repaired the gap to the attic around a one inch conduit through a. Room 116 had three sprinkler escutcheon rings the ceiling from the air handler unit dropped down away from the ceiling which left a with a one hour fire rated material 1/2 inch gap to the attic. This included the in the east hall utility room to sprinkler escutcheon ring in the room closet. meet set standards. The b. The west hall Central Bathroom was missing Administrator verified the work on the sprinkler escutcheon ring leaving a 1/2 inch 01/20/2023. gap to the attic. 2.ALL OTHERS WITH c. The middle entrance/exit short hall had a POTENTIAL TO BE AFFECTED: sprinkler escutcheon ring dropped down away 1.All residents and all staff from the ceiling which left a 1/2 inch gap to the and visitors have the potential to attic. be affected but none were. c. The middle back entrance/exit short hall had a **3.MEASURES TO PREVENT** sprinkler escutcheon ring dropped down away REOCCURRENCE: from the ceiling which left a 1/2 inch gap to the 1.On 01/18/2023. the

Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the FDC is in accordance with NFPA 25 and to ensure ceiling in sprinklered smoke compartments is maintained to allow sprinkler heads to function to their full capability and to ensure all ceiling penetrations are sealed with a one hour fire protectant material to meet set standards.

2.Maintenance Supervisor/designee will ensure the fire department connection has the appropriate signage and will ensure ceiling in sprinklered smoke compartments is

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conference.

3.1-19(b)

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d. The east hall Utility Room had a 1/2 inch gap to

the attic around a one inch conduit through the

ceiling from an air handling unit.

mentioned areas of the facility.

Based on interview at the time of each

observation, the Maintenance Supervisor

acknowledged the missing or dropped down

sprinkler escutcheon rings in the previously

and Maintenance Supervisor during the exit

This finding was reviewed with the Administrator

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274		ILDING	instruction 01	(X3) DATE : COMPL 01/18/	ETED
	ROVIDER OR SUPPLIER	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 CY MUST BE PRECEDED BY FULL LLSC 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
					maintained to allow sprinkler heads to function to their full capability and to ensure all ceipenetrations are sealed with a one-hour fire protectant materias a part of the facility's Preve Maintenance Program and document those inspection resas appropriate. If any issues discovered, they will be addresand resolved immediately. The Maintenance Supervisor/desigwill review with the Administrative 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 be presented by the Maintenan Supervisor/designee to 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 by the QA/PI Committee with subsequent plans of correction developed and implemented and deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with	ial intive sults are issed e inee itor VE will ince ince	

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155274		JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/18/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	STREET ADDRESS, CITY, STATE, ZIP COD 815 W WASHINGTON ST ROCKPORT, IN 47635			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using g complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 6 of the facility corridor non-authorized pers states 230.62 Energ shall be enclosed as guarded as specified (A) Enclosed. Energ so that they will not contact or shall be g (B) Guarded. Energ shall be installed on control board and g 110.18 and 110.27. guarded as provided means for locking of access to energized	Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 no and interview, the facility 16 electrical panels observed in 17 swere secured from 18 sonnel. NFPA 70, 2011 edition 18 ized parts of service equipment 18 specified in 230.62(A) or 19 d in 230.62(B). 19 gized parts shall be enclosed 19 de exposed to accidental 19 guarded as in 230.62(B). 19 ized parts that are not enclosed 10 a switchboard, panelboard, or 19 uarded in accordance with 19 Where energized parts are 19 in 110.27(A)(1) and (A)(2), a 10 or sealing doors providing 10 parts shall be provided. This	K 0.	TAG	all regulatory requirements. Our date of compliance is 02/06/2023. K511– It is the intent of the fact to ensure all electrical panels observed in the facility corrido are secured from non-authorize personnel to meet set standard. CORRECTIVE ACTION TAKEN: a. On 01/19/2023, the Maintenance Supervisor/design secured/locked all 6 of the electrical panels to meet set standards. The Administrator verified the work on 01/19/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTIVE. a. All residents and all states.	cility ors zed ods. iS	02/06/2023
	and visitors in the far Findings include: Based on an observ 12:10 p.m. and 2:30	ations on 01/18/23 between 0 p.m. during a tour of the			and visitors have the potential be affected but none were. O 01/19/2023, the Maintenance Supervisor/designee inspecte electrical panels and found no other negative findings. 3. MEASURES TO PREVI	n d all	
	I facility with the Ma	intenance Supervisor, all six			REOCCURRENCE:		

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electrical panels observed in the facility corridors

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On 01/18/2023, the

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CENTERS FO	ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155274	B. W	ING		01/18/	/2023
NAME OF	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATERS	S OF ROCKPORT S	SKILLED NURSING FACILITY, TI	HE	ROCKE	PORT, IN 47635		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n tested. The panels included			Administrator in serviced the		
		y of items in the facility. Based			Maintenance Supervisor/design	-	
		time of each observation, the			on the requirement that electr	ical	
	_	visor agreed all electrical			boxes must be secured from	4	
	paneis in the facility	y corridors need to be locked.			non-authorized personnel to r	neet	
	This finding was ro	viewed with the Administrator			set standards. b. Maintenance		
	_	upervisor during the exit			Supervisor/designee will inspe	net	
	conference.	upervisor during the exit			all electrical boxes throughout		
	conference.				facility monthly to ensure they		
	3.1-19(b)				secured as a part of the facilit		
					Preventive Maintenance Prog	-	
					and document those inspection		
					results as appropriate. If any		
					issues are discovered, they w		
					addressed and resolved		
					immediately. The Maintenand	ce	
					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.		
					4. MONITORING		
					CORRECTIVE ACTION:	iII	
					a. The inspection results we be presented by the Maintena		
					Supervisor/designee to the	11 10 0	
					Administrator monthly and the	2	
					Administrator will present the	•	
					inspection results at the mont	hlv	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed		

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the QA/PI Committee with subsequent plans of correction

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155274	B. WING		<u>01</u>	01/18/2023	
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		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAU	REGULATURY O	K LOC IDENTIF I ING INFORMATION		IAU	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 02/06/2023.		DATE

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