STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155274	A. BUILDING -- B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/18/23 Facility Number: 000174 Provider Number: 155274 AIM Number: 100274810 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 facility has 60 certified beds. At the time of the survey, the census was 39. Quality Review completed on 01/25/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/18/23 Facility Number: 000174 Provider Number: 155274 AIM Number: 100274810 At this Life Safety Code survey, The Waters of	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
LAURIE BARNETT	HFA	02/06/2023

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

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	Rockport Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 39 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached structures, a wood framed garage used for a maintenance shop and facility storage, as well as a wood framed house used for facility storage. Quality Review completed on 01/25/23			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 9 of 9 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents staff and visitors needing to exit the facility. Findings include: Based on observations on 01/18/23 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, all nine exit doors to the outside were posted with the incorrect code to actuate the door release. The Maintenance Supervisor was able to open the door with the correct code. Based on interview at the time of each observation, the Maintenance Supervisor agreed the correct codes should be displayed on the keypad at each exit door. These findings were reviewed with the Administrator and Maintenance Supervisor	K 0222	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **K222**– It is the intent of the facility to ensure the means of egress through exits is readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/18/2023, The	02/06/2023

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	during the exit conference. 3.1-19(b)		Maintenance Supervisor/designee posted information on how to obtain the code at all nine exit doors to meet set standards. The Administrator verified the work on. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/18/2023, the Maintenance Supervisor/designee inspected all doors to ensure information on how to obtain the codes was present and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/18/2023, the Administrator in-serviced the Maintenance Supervisor/designee and all other staff on the requirement that information to obtain the codes must be posted at the exit doors to meet set standards. b. Maintenance Supervisor/designee will inspect all means of corridor doors to ensure they have information on how to obtain the codes as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator	

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			the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/06/2023.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,			

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	toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or	K 0324	**K324**– It is the intent of the facility to ensure the kitchen exhaust system is inspected semi-annually to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. A Certified Contractor will perform the range hood exhaust system inspection by 2/12/23 and the results will be documented in the facilitie's Life Safety Binder to meet set standards. The Administrator will verify the work on 2/12/23 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one kitchen. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/18/2023, the	02/06/2023

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	oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect mostly kitchen staff, plus all residents while in the adjacent dining room. Findings include: Based on record review on 01/18/23 between 9:30 a.m. and 12:10 p.m. with the Maintenance Supervisor present, the only inspection documentation available during the past twelve months for the range hood exhaust system was dated 05/15/22. There was no range hood exhaust system inspection report available within six months after the 05/15/22 date. Based on interview at the time of record review, the Maintenance Supervisor said the facility recently changed company's to inspect the range hood exhaust system and the new company has not yet inspected the range hood. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the kitchen exhaust system must be maintained in proper working condition to meet set standards. b. Maintenance Supervisor/designee will inspect the kitchen hood system monthly to ensure the kitchen exhaust system is properly maintained as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/06/2023.**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible	K 0353	**K353** – It is the intent of the facility to ensure fire department connection is in accordance with NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of water-based fire protection systems and to ensure the ceiling in sprinklered smoke compartments is maintained to	02/06/2023

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	and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 01/18/23 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the facility's fire department connection (FDC) was located at the front side of the facility on the wall outside the sprinkler riser room. There was no FDC signage provided near the fire department connection for the responding fire department for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor who agreed there should be FDC signage near the Fire Department Connection. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 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		allow sprinkler heads to function to their full capability to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 01/31/2023, a FDC sign was ordered and will be installed by 022823 by the Maintenance Supervisor/designee at the facilities fire department connection at the front side of the facility on the wall outside the sprinkler riser room to meet set standards. The Administrator verified the work on 01/31/2023. 2. On 01/19/2023, a Maintenance Supervisor/designee repaired the three sprinkler escutcheon rings in room 116 to meet set standards. The Administrator verified the work on 01/19/2023. 3.On 01/19/2023, a Maintenance Supervisor/designee installed the sprinkler escutcheon ring in the west hall central bathroom to meet set standards. The Administrator verified the work on 01/19/2023. 4.On 01/19/2023, a Maintenance Supervisor/designee repaired the sprinkler escutcheon ring in the middle entrance/exit short hall to meet set standards. The Administrator verified the work on 01/19/2023. 5. On 01/19/2023, a Maintenance Supervisor/designee repaired the sprinkler escutcheon	

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	least 20 residents, staff, and visitors. Findings include: Based on observations on 01/18/23 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. Room 116 had three sprinkler escutcheon rings dropped down away from the ceiling which left a 1/2 inch gap to the attic. This included the sprinkler escutcheon ring in the room closet. b. The west hall Central Bathroom was missing the sprinkler escutcheon ring leaving a 1/2 inch gap to the attic. c. The middle entrance/exit short hall had a sprinkler escutcheon ring dropped down away from the ceiling which left a 1/2 inch gap to the attic. c. The middle back entrance/exit short hall had a sprinkler escutcheon ring dropped down away from the ceiling which left a 1/2 inch gap to the attic. 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. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the missing or dropped down sprinkler escutcheon rings in the previously mentioned areas of the facility. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		ring in the middle back entrance/exit short hall to meet set standards. The Administrator verified the work on 01/19/2023. 6.On 01/20/2023, a Maintenance Supervisor/designee repaired the gap to the attic around a one inch conduit through the ceiling from the air handler unit with a one hour fire rated material in the east hall utility room to meet set standards. The Administrator verified the work on 01/20/2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 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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			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 as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 02/06/2023.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 6 of 6 electrical panels observed in the facility corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on an observations on 01/18/23 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, all six electrical panels observed in the facility corridors	K 0511	**K511**– It is the intent of the facility to ensure all electrical panels observed in the facility corridors are secured from non-authorized personnel to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/19/2023, the Maintenance Supervisor/designee 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 AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/19/2023, the Maintenance Supervisor/designee inspected all electrical panels and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/18/2023, the	02/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 01 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635

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	were unlocked when tested. The panels included breakers to a variety of items in the facility. Based on interview at the time of each observation, the Maintenance Supervisor agreed all electrical panels in the facility corridors need to be locked. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		Administrator in serviced the Maintenance Supervisor/designee on the requirement that electrical boxes must be secured from non-authorized personnel to meet set standards. b. Maintenance Supervisor/designee will inspect all electrical boxes throughout the facility monthly to ensure they are secured as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/06/2023.**	