| CENTERS FOR | MEDICARE & MEDIC | | | | 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 | |
| | | 155053 | B. WING | | 04/23/2024 | |
| | | .0000 | 2 | | 0 1/20/202 4 | |
| | ROVIDER OR SUPPLIER | | 612 E ² | ADDRESS, CITY, STATE, ZIP COD | | |
| WATERS | OF RUSHVILLE S | KILLED NURSING FACILITY, TI | HE RUSH | /ILLE, IN 46173 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | ID MONUMENTS IN AN OF CONDECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION | |
| TAG | • | LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| E 0000 | | | | | | |
| Bldg | conducted by the In accordance with 42 Survey Date: 04/23 Facility Number: 0 Provider Number: 1002 At this Emergency 1 | 3/24 00018 155053 273930 Preparedness survey, The | E 0000 | Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by facility of the facts alleged o conclusions set forth in this statement of deficiencies. The plan of correction and speci corrective actions are prepared and/or executed in compliant. | nn this r he fic red | |
| | found in compliance Preparedness Requi Medicaid Participat CFR 483.73. | rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 36. | | with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance w Federal Medicare and Medicaid requirements. This facility requests paperwork compliance. | ith | |
| K 0000 | | | | | | |
| Bldg. 01 | Licensure Survey w Department of Heal 483.90(a). Survey Date: 04/23 Facility Number: 0 Provider Number: 1002 | 00018 155053 | K 0000 | Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by facility of the facts alleged o conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliant with state and federal laws. | nn this r he fic red | |
| | 731 uns Life Safety | code survey, The waters of | | with state and lederal idws. | | |

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

(X6) DATE

TITLE

Diana Gore Administrator 05/09/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NKHO21 Facility ID: 000018 If continuation sheet Page 1 of 23

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | ` ′ | JILDING | nstruction 01 | COME | E SURVEY PLETED 3/2024 |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, TH | E | 612 E 1 | NDDRESS, CITY, STATE, ZIP COD 1TH ST ILLE, IN 46173 | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| | in compliance with in Medicare/Medica Life Safety from Fit National Fire Protec Life Safety Code (L | ursing Facility was found not Requirements for Participation and, 42 CFR Subpart 483.90(a), re and the 2012 edition of the extion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. | | | This plan of correction constitutes a written alle of substantial compliant Federal Medicare and Medicaid requirements. facility requests paperwoompliance. | e with | |
| | Type V (000) construction The facility has a find etection in the corricorridors and batter all resident sleeping | ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors, spaces open to the y-operated smoke detectors in rooms. The healthcare ry has a capacity of 98 and had be time of this visit. | | | | | |
| | were sprinkled and services were sprink detached wooden st not sprinkled. | dents have customary access all areas providing facility dered. The facility had two orage buildings which were | | | | | |
| K 0131 SS=E Bldg. 01 | Care Facilities Sections of health other occupancies o They are not in more inpatients fo treatment, or custo o They are separ care occupancies | cies cies - Sections of Health care facilities classified as meet all of the following: tended to serve four or r purposes of housing, omary access. rated from areas of health by aving a minimum two hour ng in | | | | | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 2 of 23

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | |
|-----------|-------------------------|---------------------------------------------------|-------------------------------------------|---------------------|------------------------------------------------------------------------|-----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPLETED | | |
| | | 155053 | B. W | NG | | 04/23 | 04/23/2024 | |
| | | <u> </u> | | STREET | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF 1 | PROVIDER OR SUPPLIE | R | | | 11TH ST | | | |
| WATERS | S OF RUSHVILLE S | SKILLED NURSING FACILITY, THI | E | RUSHVILLE, IN 46173 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | 1 | NCY 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 | |
| | | ding is protected throughout | | | | | | |
| | by an approved, s | · · | | | | | | |
| | • | nkler system in accordance | | | | | | |
| | with Section 9.7. | | | | | | | |
| | l la amital avita ation | -t | | | | | | |
| | | nt surgical departments are | | | | | | |
| | | ssified as an Ambulatory upancy regardless of the | | | | | | |
| | number of patient | · · · · | | | | | | |
| | | 482.41, 42 CFR 485.623 | | | | | | |
| | | on and interview, the facility | $ _{K0}$ | 131 | K131– It is the intent of the fa | cility | 05/14/2024 | |
| | | of 1 separation fire doors would | I K U | 131 | to ensure separation fire door | - | 03/14/2024 | |
| | | fire and restrict the movement | | | would limit the spread of fire a | | | |
| | _ | .1.1.3 requires all health care | | | restrict the movement of smol | | | |
| | | ntained and operated to | | | meet set standards. | | | |
| | | bility of a fire emergency | | | 1 CORRECTIVE ACTIONS | S | | |
| | | nation of the occupants. LSC | | | TAKEN: | | | |
| | | opening in a fire barrier shall | | | a On 4/24/24, the | | | |
| | be protected to lim | it the spread of fire and restrict | | | Maintenance Supervisor/design | gnee | | |
| | the movement of si | moke from one side of the fire | | | repaired the double set of bar | rier | | |
| | barrier to the other. | . This deficient practice could | | | doors near resident room 61 t | .о | | |
| | affect 25 residents. | | | | ensure they close and latch to |) | | |
| | | | | | meet set standards. The | | | |
| | Findings include: | | | | Administrator verified the repa | air on | | |
| | | | | | 4/24/24 . | | | |
| | | on and interview with the | | | 2 ALL OTHERS WITH | | | |
| | | the Maintenance Director (MD) | | | POTENTIAL TO BE AFFECT | | | |
| | | en 11:45 a.m. and 2:20 p.m., the | | | a All residents and all staf | | | |
| | | er doors near Resident Room 61 | | | and visitors have the potentia | | | |
| | | atch. This set of doors | | | be affected but none were. O | 'n | | |
| | _ | ed and Assisted Living sections | | | 5/8/24, the Maintenance | | | |
| | | MD acknowledged these | | | Supervisor/designee inspecte | | | |
| | | ot latch. The MD stated that | | | other areas and found no other | ∍r | | |
| | | rs appeared to be sticking on | | | negative findings. | · NIT | | |
| | the carpet. | | | | 3 MEASURES TO PREVE | .N I | | |
| | This finding was a | oknowledged by the | | | REOCCURRENCE: | rator | | |
| | | cknowledged by the Maintenance Director at the | | | a On 5/8/24, the Administr | สเปโ | | |
| | | and again at the exit conference | | | inserviced the Maintenance | nt to | | |
| | | ator and Maintenance Director | | | Supervisor on the requirement | | | |

| | OF CORRECTION | IDENTIFICATION NUMBER 155053 | A. BUILDING B. WING | 01 | COMPLETED 04/23/2024 |
|--------------------------|---------------------|----------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | 612 E 1 | ADDRESS, CITY, STATE, ZIP COD 1TH ST /ILLE, IN 46173 | |
| (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 |
| | present. 3.1-19(b) | | | would limit the spread of fire a to ensure they close and latch meet set standards. b Maintenance Supervisor/designee will insped all doors throughout the facility monthly to ensure they would the spread of fire and to ensure they close and latch as a part the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/designed will review with the Administration 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 presented by the Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results when 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 QA/PI Committee with subsequent plans of correction developed and implemented and deemed necessary to ensure | ect / limit ee of sults are ssed ee gnee tor ill nce |

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | (X2) MULTIF A. BUILDII B. WING | PLE CONSTRUCTION NG <u>01</u> | COMP | E SURVEY PLETED 3/2024 |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, TH | 61 | REET ADDRESS, CITY, STATE, ZIP CO 2 E 11TH ST JSHVILLE, IN 46173 | D | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREF TA | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP | ECTION OULD BE 'PROPRIATE | (X5) COMPLETION DATE |
| | | | | compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirem. Our date of compliance 5/14/24. | le ce with nents. | |
| K 0211 SS=E Bldg. 01 | in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of egresses were continuous tructions. LSC 1 into the required with wheeled equipment following condition (a) The wheeled equipment clear unobstructed of in.(1525 mm). (b) The health care training program and wheeled equipment emergency. (c) The wheeled equipment in use ii. Medical emergency iii. Patient lift and to | regeneral ays, corridors, exit cations, and accesses are in Chapter 7, and the means uously maintained free of full use in case of is modified by 18/19.2.2 in and interview, the facility fover 4 corridor means of inuously maintained free of 19.2.3.4 (4) states projections dith shall be permitted for inprovided that all of the is are met: Inipment does not reduce the corridor width to less than 60 incompany fire safety plan and inderest the relocation of the during a fire or similar injuries is limited to the individual and carts in use incompany for the cycle of the cycle of the injuries in the cycle of the injuries injuries in the cycle of the injuries in the cycle of the injuries in the cycle of the injuries injuries in the cycle of the injuries injuries in the cycle of the injuries in | K 0211 | K211– It is the intent of to ensure corridor mean egresses are continuous maintained free of obstrated meet set standards. 1 CORRECTIVE ACTAKEN: a On 4/23/24, the Maintenance Superviso removed the nighstand corridor near the soiled to meet set standards. Administrator verified the 4/23/24. 2 ALL OTHERS WITHOUTH POTENTIAL TO BE AFTE A MITHER STORE AND | r/designee in the utility room The e work on TH FECTED: all staff otential to ere. | 05/14/2024 |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 5 of 23

| | VT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | (X2) MULTIPLE CO A. BUILDING B. WING | | NSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 04/23/2024 | |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | 61 | 2 E 11 | DDRESS, CITY, STATE, ZIP COD TH ST LLE, IN 46173 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION | ID PREF TA | TIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| TAG | Findings include: Based on observation Administrator and to on 04/23/24 between corridor near the so which did not have corridor. Based on a observations, the M would need to be much this finding was ac Administrator and M time of discovery and management of the control of the correction of the cor | on and interview with the he Maintenance Director (MD) in 11:45 a.m. and 2:20 p.m. in the ided utility room, a nightstand, wheels, was sitting in the in interview at the time of D stated the night stand oved. | TA | | a On 5/8/24, the Administration inserviced the Maintenance Supervisor/designee and all ostaff will be inserviced on 5/14 on the requirement to ensure corridor means of egress are continuously maintained free cobstructions to meet set standards. b Maintenance Supervisor/designee will ensure corridor means of egress are continuously maintained free cobstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designee will review with the Administration 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 we be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system | rator ther ther t/24 of re of sults are ssed ne gnee ttor ill nce thy ce | DATE |

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | r ′ | ILDING | nstruction <u>01</u> | (X3) DATE (COMPL 04/23 / | ETED |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | ≣ | 612 E 1 | NDDRESS, CITY, STATE, ZIP COD 1TH ST ILLE, IN 46173 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | | | | components will be reviewed 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 5/14/24. | n as | |
| K 0222 SS=E Bldg. 01 | be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carring other such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Security staff. | king arrangements for the seds of the patient are sking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1, | | | | | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 7 of 23

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | | ILDING | onstruction 01 | (X3) DATE : COMPL 04/23 / | ETED |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | | 612 E 1 | ADDRESS, CITY, STATE, ZIP COD 1TH ST ILLE, IN 46173 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY 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) | ΓE | (X5) COMPLETION DATE |
| | release upon loss building is protect automatic sprinkle space is protected detection system at an attended los space); and both systems are arranupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed on systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superdetection systems automatic sprinkles 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRANACCESS-CONTR LOCKING ARRANAC | SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an sed automatic sprinkler | K 02 | 222 | K222– It is the intent of the fac | illity | 05/14/2024 |
| | | means of egress through 1 of | K 0. | LLL | to ensure means of egress | лпц | U3/14/2U24 |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 8 of 23

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/23/2024 | |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| | PROVIDER OR SUPPLIER S OF RUSHVILLE SKILLED NURSING FACILITY, TH | 612 E 1 | DDRESS, CITY, STATE, ZIP COD 1TH ST ILLE, IN 46173 | | |
| | | 612 E 1 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) through exits is readily access for residents without a clinical diagnosis required specialized security measures to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 4/25/24, the Maintenance Supervisor/designosted the correct code at the door #3 to meet set standards. The Administrator verified the on 4/25/24. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff and visitors have the potential be affected but none were. Of 5/8/24, the Maintenance Supervisor/designee inspected doors and found no other negatindings. 3 MEASURES TO PREVE REOCCURRENCE: a On 5/8/24, the Administr inserviced the Maintenance Supervisor/designee to ensure facility exit codes are posted | ible ible inee exit work ED: to n d all attive NT ator | |
| | 3.1-19(0) | | correctly to meet set standards b Maintenance Supervisor/designee will ensu the facility exit codes posted a correct facility's monthly Preventive Maintenance Progrand document those inspectio results as appropriate. If any issues are discovered, they wi addressed and resolved immediately. The Maintenance Supervisor/designee will review | re re ram n II be | |

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155053 | A. BUILDING B. WING | 01 | COMPLETED 04/23/2024 |
|----------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | 612 E 1 | ADDRESS, CITY, STATE, ZIP COD 1TH ST /ILLE, IN 46173 | |
| (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 0301 | NEDA 404 | | | 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 who 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 all regulatory requirements. Our date of compliance is 5/14/24. | nity ce . cy nis |
| K 0291 SS=F Bldg. 01 | duration is provide accordance with 7 18.2.9.1, 19.2.9.1 | ng g of at least 1-1/2-hour d automatically in | K 0291 | K291 – It is the intent of the | 05/14/2024 |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 10 of 23

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|------------------------------------------------------|----------------------|-----------------------------------------------------------------|-----------------------------|-------------|---------------------------------------------------------------------|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPI | | | | |
| | | 155053 | B. W | ING | | 04/23 | /2024 |
| NAME OF I | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | 612 E 1 | I1TH ST | | |
| WATERS | S OF RUSHVILLE S | SKILLED NURSING FACILITY, THI | E | RUSHV | /ILLE, IN 46173 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | NCY 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 |
| | | e facility failed to provide | | | facility to ensure to provide | | |
| | | lighting for all exits. LSC | | | exterior emergency lighting for | r all | |
| | | uires emergency lighting | | | exits to meet set standards. | | |
| | | of egress shall be provided for | | | 1.CORRECTIVE ACTIONS | | |
| | | exit discharge. This deficient | | | TAKEN: | | |
| | _ | ct all occupants in the facility | | | 1.On 5/9/24, the | | |
| | _ | itors and residents if the facility vacuate in an emergency and | | | Maintenance Supervisor/desi | - | |
| | • | providing electricity at that | | | ensured all the exterior exit lig | gnts | |
| | | nt practice could affect everyone | | | are connected to the facility | rdo. | |
| | in the facility. | it practice could affect everyone | | | generator to meet set standar The Administrator verified the | | |
| | in the facility. | | | | on 5/9/24. | WOIK | |
| | Findings include: | | | | 2.ALL OTHERS WITH | | |
| | i manigs metade. | | | | POTENTIAL TO BE AFFECT | ED. | |
| | Based on observati | on and interview with the | | | 1.All residents and all sta | | |
| | | the Maintenance Director (MD) | | | and visitors have the potentia | | |
| | | en 11:45 a.m. and 2:20 p.m., it | | | be affected but none were. | 110 | |
| | | e exterior lights for the exit | | | 3.MEASURES TO PREVEN | т | |
| | | the facility exits were | | | REOCCURRENCE: | | |
| | _ | enerator. The MD was unsure | | | 1.On 5/8/24, the | | |
| | _ | from looking at the panels, and | | | Administrator inserviced the | | |
| | no further verificat | ion or documentation was | | | Maintenance Supervisor/desi | gnee | |
| | available to verify | the facilities exit lighting which | | | on the requirement to ensure | - | |
| | | ne exit discharges was | | | facility exit lights are connected | ed to | |
| | connected to the ge | enerator and could illuminate in | | | the emergency generator and | I | |
| | the event of a power | er outage. | | | labeled and documented to m | neet | |
| | This finding was a | cknowledged by the | | | set standards. | | |
| | | Maintenance Director at the | | | 2.Maintenance | | |
| | 1 | and again at the exit conference | | | Supervisor/designee will ensu | | |
| | with the Administr | ator and Maintenance Director | | | facility exit lights are connected | | |
| | present. | | | | the generator as a part of the | | |
| | | | | | facility's monthly Preventive | | |
| | 3.1-19(b) | | | | Maintenance Program and | | |
| | | | | | document those tests on the | | |
| | | | | | Battery-Operated Emergency | | |
| | | | | | Lights and signs Test Log and | | |
| | | | | | maintain emergency lighting t | 0 | |
| | | | | | meet set standards. If any | | |
| | | | | | issues are discovered, they w | ıll be | |
| | | | 1 | | addressed and resolved | | 1 |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | | LDING | onstruction 01 | (X3) DATE SURVEY COMPLETED 04/23/2024 |
|----------------------------|------------------------------------------------|-------------------------------------------------------------------------------------|-----|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| | PROVIDER OR SUPPLIE | R SKILLED NURSING FACILITY, TH | IE. | 612 E 1 | ADDRESS, CITY, STATE, ZIP COD 1TH ST (ILLE, IN 46173 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | I | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | REGULATOR I O | LEC BEATH THIS BY OKWATION | | | immediately. The Maintenand 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 CORRECT ACTION: 1. The inspection results to be presented by the Maintenan Supervisor/designee to 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 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 5/14/24. | iVE will nce hly ce l. by n as |
| K 0321 SS=E Bldg. 01 | NFPA 101 Hazardous Areas Hazardous Areas | - Enclosure | | | | |
| | barrier having 1-h | are protected by a fire nour fire resistance rating | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 | | (X2) MULTIPLE (A. BUILDING B. WING | CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 04/23/2024 | |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, TH | 612 E | r Address, City, State, Zip Cod 11TH ST IVILLE, IN 46173 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY 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) | (X5) COMPLETION DATE |
| | accordance with 8 approved automation is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32). Based on observation failed to ensure 1 of such as storage roof properly working so deficient practice count visitors. Findings include: Based on observation. | and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) hance, and Paint Shops boms (exceeding 64 In Rooms lons) brage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility of over 10 hazardous area doors, ms, were provided with elf-closing devices. This build affect more than 3 staff | K 0321 | K321 - It is the intent of the fat to ensure hazardous area doc are provided with properly wo self-closing devices to meet standards. 1 CORRECTIVE ACTIONS TAKEN: a On 4/25/24, the Maintenance Supervisor/designemoved all hazardous items | ors rking et S gnee from |
| I | I Administrator and t | he Maintenance Director (MD) | 1 | room 36 to meet set standard | e l |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | | SURVEY | | |
|------------------------------------------------------|----------------------|----------------------------------------|-------|----------|---------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | COMPL | ETED |
| | | 155053 | B. WI | NG | | 04/23/ | 2024 |
| | | | | STREET 4 | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | 1TH ST | | |
| WATERS | OF RUSHVILLES | KILLED NURSING FACILITY, THE | : | | /ILLE, IN 46173 | | |
| | | | | | , | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | n 11:45 a.m. and 2:20 p.m., RR # | | | The Administrator verified the | work | |
| | | square feet contained a number | | | on 4/25/24. | | |
| | | as, including 9 upholstered | | | 2 ALL OTHERS WITH | | |
| | - | e corridor door to this room did | | | POTENTIAL TO BE AFFECTE | | |
| | | atch into the door frame. | | | a All residents and all staff | | |
| | This finding was ac | | | | and visitors have the potential | to | |
| | | Maintenance Director at the | | | be affected but none were. | | |
| | | nd again at the exit conference | | | 3 MEASURES TO PREVE | NT | |
| | | tor and Maintenance Director | | | REOCCURRENCE: | _4 | |
| | present. | | | | a On 5/8/24, the Administr | alor | |
| | 2.1.10(%) | | | | in serviced the Maintenance | | |
| | 3.1-19(b) | | | | Supervisor/designee on the | | |
| | | | | | requirement to ensure hazardo | | |
| | | | | | areas have self-closing locked doors or that all hazardous ite | | |
| | | | | | are removed to meet set | 1115 | |
| | | | | | standards. | | |
| | | | | | b Maintenance | | |
| | | | | | Supervisor/designee will inspe | ect | |
| | | | | | all hazardous area rooms | ,01 | |
| | | | | | throughout the facility to ensur | ·e | |
| | | | | | they have working self-closing | | |
| | | | | | devices or hazardous items ar | | |
| | | | | | removed as a part of the facilit | | |
| | | | | | monthly Preventive Maintenar | - | |
| | | | | | Program and document those | | |
| | | | | | inspection results as appropria | ate. | |
| | | | | | If any issues are discovered, t | | |
| | | | | | will be addressed and resolve | - | |
| | | | | | immediately. The Maintenanc | e | |
| | | | | | 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 | | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet Page 14 of 23

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155053 | A. BUILDING B. WING | 01 | COMPLETED 04/23/2024 |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | 612 E 1 | ADDRESS, CITY, STATE, ZIP COD 1TH ST /ILLE, IN 46173 | |
| (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 0325 SS=E | | nd Rub Dispenser (ABHR) | | a The inspection results we be presented by the Maintenan Supervisor/designee to the 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 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 5/14/24. | nily ce by |
| Bldg. 01 | ABHRs are protect 8.7.3.1, unless all * Corridor is at lea * Maximum individ 0.32 gallons (0.53 and 18 ounces of * Dispensers shall horizontal spacing * Not more than ar fluid or 135 ounces single smoke com | ual dispenser capacity is gallons in suites) of fluid Level 1 aerosols have a minimum of 4-foot | | | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 15 of 23

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 | | A. BUILDING <u>01</u> CC | | | (X3) DATE COMPL 04/23 / | ETED | | |
|----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------|
| | | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173 | | | | |
| | (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | per room * Storage in a sing greater than 5 gall 30 * Dispensers are ran ignition source * Dispensers over sprinklered smoke and the with Section 18.3. * ABHR does not access 18.3.2.6, 19.3.2.6, 460, 482, 483, and Based on observation failed to ensure 3 of sanitizer dispensers ignition source. NF states dispensers should be source (b) To the side of an 1-inch horizontal distance source (b) To the side of an 1-inch horizontal distance source (b) To the side of an 1-inch horizontal distance from This deficient practical distance from This deficient prac | gle smoke compartment lons complies with NFPA not installed within 1 inch of carpeted floors are in e compartments exceed 95 percent alcohol dispenser shall comply 2.6(11) or 19.3.2.6(11) ed against inappropriate , 42 CFR Parts 403, 418, d 485 on and interview, the facility f over 20 alcohol-based hand were not installed over an PA 101, Section 19.3.2.6(8) all not be installed in the | K 0. | 325 | K325— It is the intent of the facto ensure alcohol-based hand sanitizer dispensers are not installed over an ignition source meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 4/26/24, the Maintenance Supervisor/designelocated the alcohol-based has anitizer dispensers away from ignition source near rooms 51, and 14 to meet set standards. The Administrator verified the on 4/26/24. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE and visitors have the potential be affected but none were. Of 4/26/24, the Maintenance Supervisor/designee inspected location of all alcohol-based has anitizer dispensers and found other negative findings. | gnee and n an , 16 work ED: to n | 05/14/2024 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/23/2024 | | | | |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173 | | | | | |
| (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 | | | |
| PREFIX | (EACH DEFICIEN REGULATORY OR dispenser was instal an electrical outlets This finding was ac Administrator and M time of discovery an | CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION lled on the wall directly above | PREFIX | 3 MEASURES TO PREVERED TO THE APPROPRIATE ACTION SHOULD BE CROSS-REFERENCED THE APPROPRICED THE ACTION SHOULD BE COMMITTED THE APPROPRICED THE ACTION SHOULD BE CALLED TO THE APPROPRICED THE ACTION THE APPROPRICED THE ACTION TO THE APPROPRICED THE ACTION TO TH | gnee son s. ect eers y to iity's gram on y iill be ce | | | |
| | | | | documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results v be presented by the Maintena | | | | |
| | | | | Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting | hly ce | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 01 COMPLETE B. WING 04/23/202 | | | ETED | | |
|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | KILLED NURSING FACILITY, THE | STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173 | | | | |
| (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 APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | | | | | 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 5/14/24. | n s | |
| K 0761 SS=E Bldg. 01 | | | | | | | |
| | interview, the facilitinspection and testin assemblies were con 19.1.1.4.1.1 commutative barriers required permitted only in comparative by approved self-cle (See also Section 8. required to have a factor of the section 19.3.4.2 shall be protabled fire door assemblies and their including all frames and sills in accordan NFPA 80, Standard Opening Protectives specified in this Condoor assemblies shalless than annually, a inspection shall be selected. | on, records review, and ty failed to ensure annual ing of at least 1 fire door impleted in accordance of LSC inicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table freeted by approved, listed, semblies and fire window or accompanying hardware, see, closing devices, anchorage, free with the requirements of for Fire Doors and Other of the sexuent as otherwise de. NFPA 80 5.2.1 states fire find a written record of the freeding and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both | K 01 | 761 | K761 – It is the intent of the facility to ensure annual inspect and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1. communicating openings in dividing fire barriers required by 19.1.1.4.1 communicating openings in dividing fire barrier required by 19.1.1.4.1 be permitted only in corridors and shall be protected by approved self-closing fire door assemblied meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 5/9/24, the Maintenar Supervisor/designee conducted the annual inspection for the fidoor assembly at the Oxygen Transfilling Room and docume the inspection results on the Annual Door Inspections log to | 1 y rs d es to c c c c c c c c c c c c c | 05/14/2024 |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet Page 18 of 23

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE S | (3) DATE SURVEY | |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------|---------------------------------------------------------------------------------------------------------|----------------------------------|-----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> | | | COMPLETED | |
| | | 155053 | B. WI | NG | | 04/23/2 | 2024 |
| NAME OF P | DOUDED OF CUIPNITE | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 612 E 1 | 1TH ST | | |
| WATERS | OF RUSHVILLE S | KILLED NURSING FACILITY, THE | <u> </u> | RUSHV | /ILLE, IN 46173 | | |
| (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 APPROPRI | | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, | | | | meet set standards. The | | |
| | | | | | Administrator verified the | | |
| | the following items | | | | inspections and documentatio | n on | |
| | | r breaks exist in surfaces of | | | 5/9/24. | | |
| | either the door or fr | | | | 2 ALL OTHERS WITH | | |
| | | light frames, and glazing beads | | | POTENTIAL TO BE AFFECTE | I | |
| | | ely fastened in place, if so | | | a All residents and all staff | | |
| | equipped. | | | | and visitors have the potential | to | |
| | | , hinges, hardware, and | | | be affected but none were. | | |
| | | eshold are secured, aligned, | | | 3 MEASURES TO PREVE | NT | |
| | | er with no visible signs of | | | REOCCURRENCE: | | |
| | damage. | | | | a On 5/8/24 the | | |
| | (4) No parts are missing or broken. | | | | Administrator/corporate Prope | erty | |
| | ` / | do not exceed clearances | | | Manager inserviced the | | |
| | listed in 4.8.4 and 6 | | | | Maintenance Supervisor/desig | | |
| | | device is operational; that is, | | | on the requirement that annua | | |
| | | pletely closes when operated | | | testing & inspections of fire do | | |
| | from the full open p | | | | assemblies including the oxyg | en | |
| | * * | is installed, the inactive leaf | | | transfilling room must be | | |
| | closes before the ac | | | | conducted to ensure proper | | |
| | | are operates and secures the | | | operation and documented on | | |
| | door when it is in th | - | | | Annual Door Inspections log to | ٥ | |
| | | vare items that interfere or | | | meet set standards. | | |
| | | re not installed on the door or | | | b Maintenance | | |
| | frame. | *4:44 | | | Supervisor/designee will cond | | |
| | 1 1 | ications to the door assembly | | | the annual inspection of fire do | | |
| | - | ed that void the label. | | | assemblies including the oxyg | | |
| | ` ' | edge seals, where required, are | | | transfilling room to ensure pro | per | |
| | | their presence and integrity. | | | operation and document the | | |
| | i nis delicient practi | ice could affect 20 residents. | | | inspection results on the Annu | | |
| | Findings include: | | | | Door Inspection log as a part of | וט | |
| | Findings include: | | | | the facility's Preventive | | |
| | Dagad on massard | view and interview with the | | | Maintenance Program and | aulto | |
| | | | | | document those inspection res | | |
| | | he Maintenance Director (MD) | | | as appropriate. If any issues | | |
| | on 04/23/24 between 9:50 a.m. and 11:45: a.m., no documentation of an annual inspection for the fire | | | | discovered, they will be addre | | |
| | | | | | and resolved immediately. Th | | |
| | | e Oxygen Transfilling room | | | Maintenance Supervisor/desig | | |
| | | view. Based on observation | | | will review with the Administra | tor | |
| during the tour the Oxygen Transfilling room has | | 1 | | the inspection results. | | | |

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053 | lì í | UILDING | onstruction 01 | (X3) DATE : COMPL 04/23/ | ETED | |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIEF | KILLED NURSING FACILITY, TH | IE. | STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY 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 | |
| | interview at the tim observation, the MI inspection was not of the This finding was ac Administrator and I time of discovery a with the Administrator present. 3.1-19(b) | door assembly. Based on e of records review and D stated the annual fire door completed within the last year. knowledged by the Maintenance Director at the nd again at the exit conference ator and Maintenance Director | | | 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 where the presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed 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 5/14/24. | nce hly ce by n | | |
| K 0920 SS=E Bldg. 01 | Extens Electrical Equipmone Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb | ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet | | | | | | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet Page 20 of 23

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | | SURVEY | |
|---------------------------|---------------------------------------------------------------------------------------|------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPI | LETED |
| | | 155053 | B. W | NG | | 04/23 | /2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | I1TH ST | | |
| WATERS | S OF RUSHVILLE S | SKILLED NURSING FACILITY, TH | F | | /ILLE, IN 46173 | | |
| | 1 | · | _ | | T | | |
| (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 APPROPRIATE DEFICIENCY) | | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCE | | DATE |
| | | 10.2.3.6. Power strips in | | | | | |
| | • | icinity may not be used for | | | | | |
| | , - | , personal electronics), | | | | | |
| | except in long-term care resident rooms that do not use PCREE. Power strips for PCREE | | | | | | |
| | | r UL 60601-1. Power strips | | | | | |
| | for non-PCREE in the patient care rooms | | | | | | |
| | (outside of vicinity) meet UL 1363. In | | | | | | |
| | non-patient care rooms, power strips meet | | | | | | |
| | - | ds. All power strips are | | | | | |
| | | precautions. Extension | | | | | |
| | cords are not used as a substitute for fixed | | | | | | |
| | wiring of a structure. Extension cords used | | | | | | |
| | temporarily are re | moved immediately upon | | | | | |
| | completion of the | purpose for which it was | | | | | |
| | installed and mee | ts the conditions of 10.2.4. | | | | | |
| | 10.2.3.6 (NFPA 9 | 9), 10.2.4 (NFPA 99), 400-8 | | | | | |
| | | (D) (NFPA 70), TIA 12-5 | | | | | |
| | | ation and interview, the facility | K 0 | 920 | K920 – It is the intent of the | | 05/14/2024 |
| | | f 1 flexible cords were not used | | | facility to ensure flexible cords | | |
| | | ixed wiring. NFPA-70/2011, | | | not used as a substitute for fix | | |
| | | pecifically permitted in 400.7 | | | wiring and to ensure power st | - | |
| | | eables shall not be used for (1) | | | are not used as a substitute fo | or | |
| | | ixed wiring. This deficient | | | fixed wiring to provide power | | |
| | * | et up to 1 staff in the boiler | | | equipment with a high current | | |
| | room. | | | | draw to meet set standards. | | |
| | Findings include: | | | | 1.CORRECTIVE ACTIONS | | |
| | rindings include. | | | | TAKEN: 1.On 4/24/24 the | | |
| | Based on observation | on and interview with the | | | Maintenance Supervisor/desig | nee | |
| | | the Maintenance Director (MD) | | | removed the extension cords | | |
| | | en 11:45 a.m. and 2:20 p.m. in the | | | the boiler area to meet set | 5111 | |
| | | nsion cord which was plugged | | | standards. The Administrator | | |
| | | nen into another extension | | | verified the removal on 4/24/2 | | |
| | cord which appeare | ed to go outside. The MD was | | | 2.On 4/24/24, the | | |
| | | tension cords were powering, | | | Maintenance Supervisor/desig | nee | |
| | he speculated perhaps a sump. | | | | removed a power strip from th | | |
| | | - | | | West Nurses Station area to n | | |
| | This finding was ac | knowledged by the | | | set standards. The Administra | ator | |
| | | Maintenance Director at the | | | verified the removal on 4/24/2 | 4. | |

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

Event ID:

NKHO21 Facility ID: 000018

If continuation sheet

Page 21 of 23

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|------------------------------------------------------|----------------------------------------------------|-----------------------------------|---------------------------------------------|----------|---------------------------------------------------------------------------------------------------------|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> | | | COMPLETED | |
| | | 155053 | B. WIN | NG | | 04/23/ | 2024 |
| | | | ' | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | 612 E 1 | | | |
| WATERS | OF RUSHVILLE S | KILLED NURSING FACILITY, THE | | | 'ILLE, IN 46173 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | F | 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 |
| | time of discovery as | nd again at the exit conference | | | 2.ALL OTHERS WITH | | |
| | with the Administra | ntor and Maintenance Director | | | POTENTIAL TO BE AFFECTE | ED: | |
| | present. | | | | 1.All residents and all sta | ff | |
| | | | | | and visitors have the potential | to | |
| | | ation and interview, the facility | | | be affected but none were. O | n | |
| | failed to ensure 1 of 1 power strips were not used | | | | 4/25/24 the Maintenance | | |
| | | xed wiring to provide power | | | Supervisor/designee inspected | | |
| | equipment with a hi | ~ | | | rooms throughout the facility fo | | |
| | · · | 0.8 state unless specifically | | | power strips and found no oth | er | |
| | * | flexible cords and cables shall | | | negative findings. | | |
| | | as a substitute for fixed wiring. | | | 3.MEASURES TO PREVEN | Т | |
| | This deficient practice could affect up to 2 | | | | REOCCURRENCE: | | |
| | residents and 2 staff in the nurses station. | | | | 1.On 5/14/24, the | | |
| | | | | | Administrator inserviced the | | |
| | Findings include: | | | | Maintenance | | |
| | | | | | Supervisor/designee/all other | staff | |
| | | on and interview with the | | | that flexible cords and power | | |
| | | he Maintenance Director (MD) | | | strips are not to be used as a | | |
| | | n 11:45 a.m. and 2:20 p.m. in the | | | substitute for fixed wiring to m | eet | |
| | | n area a power strip was being | | | set standards. | | |
| | - | rm style refrigerator (high | | | 2.Maintenance | | |
| | power draw equipm | nent). | | | Supervisor/designee will inspe | | |
| | Tl.:- £:- 1' | l | | | all rooms throughout the facilit | - | |
| | This finding was ac | | | | monthly to ensure they do not | | |
| | | Maintenance Director at the | | | have flexible cords or power s | | |
| | · · | nd again at the exit conference | | | in use as a part of the facility's | | |
| | | ator and Maintenance Director | | | Preventive Maintenance Progr | | |
| | present. | | | | and document those inspectio | | |
| | 3.1-19(b) | | | | results as appropriate. If any issues are discovered, they wi | | |
| | 3.1-19(0) | | | | addressed and resolved | ii be | |
| | | | | | | | |
| | | | | | immediately. The Maintenand | | |
| | | | | | Supervisor/designee will reviewith the Administrator the | vv | |
| | | | | | inspection results. | | |
| | | | | | 3.The Administrator will | | |
| | | | | | monitor adherence to the | | |
| | | | | | Preventative Maintenance | | |
| | | | | | schedule and validate the | | |
| | | | | | Preventative Maintenance | | |
| | | | 1 | | i icventative maintenance | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/14/2024
FORM APPROVED

| CENTERS FOR | MEDICARE & MEDIC | AID SERVICES | | | | OM | B NO. 0938-039 | | |
|------------------------------------------------------|---------------------|------------------------------|---------------|--------------------------------------|------------------------------------------------------------------------|------------|----------------|--|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE C | ONSTRUCTION | (X3) DATE | SURVEY | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPL | ETED | | |
| | | 155053 | B. WING | | · | 04/23/2024 | | | |
| | | | | | | <u> </u> | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | | | | |
| | | | 612 E 11TH ST | | | | | | |
| WATERS | OF RUSHVILLE S | KILLED NURSING FACILITY, THE | | RUSHVILLE, IN 46173 | | | | | |
| (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 | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | | |
| | | | | | documentation is in place. | | | | |
| | | | | | 4.MONITORING CORRECTI | VE | | | |
| | | | | | ACTION: | | | | |
| | | | | | 1.The inspection results v | will | | | |
| | | | | | be presented by the Maintena | | | | |
| | | | | | Supervisor/designee to the | | | | |
| | | | | | Administrator monthly and the | , | | | |
| | | | | | Administrator will present the | | | | |
| | | | | | inspection results at the month | าไV | | | |
| | | | | | 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 | า | | | |
| | | | | | developed and implemented a | | | | |
| | | | | | deemed necessary to ensure | - | | | |
| | | | | | compliance is maintained. | | | | |
| | | | | | This plan of correction | | | | |
| | | | | | constitutes our credible | | | | |
| | | | | | allegation of compliance with | n | | | |
| | | | | | all regulatory requirements. | • | | | |
| | | | | | Our date of compliance is | | | | |
| | | | | | 5/14/24. | | | | |
| | | | | | 3/14/24. | | | | |
| | | | | | | | | | |
| | | | | | • | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NKHO21 Facility ID: 000018 If continuation sheet Page 23 of 23