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

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPL 09/14/	ETED
	ROVIDER OR SUPPLIER	D NURSING FACILITY, THE		317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0	000	29 September 2023		
	Waters of Peru Skil in compliance with Requirements for M Participating Provid 483.73. The facility census of 38 at the total control of the state o	200014 55039 288670 Preparedness survey, The led Nursing Facility was found Emergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR has a capacity of 130 and had a			Indiana State Department of Health Attn: Brenda Buroker, Director Long Term Care 2 North Meridian Street Indianapolis, In 46204 RE: Survey Event ID NQN92 Dear Ms. Buroker, Please accept the enclosed pof correction as a credible allegation of compliance to the deficiencies cited during our Safety Survey conducted on 14, 2023 at Water's of Perulatest date of compliance will September 27, 2023. Hopefully you will find that our remedies are sufficient. Wat of Peru is respectfully request paper compliance. If after reviewing our plan of correction, you have question require further information, plan on the sitate to call me at you convenience at 765-473-442 Sincerely, Debbie Coppernoll, HFA	olan ne Life Sept Our be ur er's sting	

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

TITLE

(X6) DATE

Debbie L Coppernoll Administrator 09/29/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		(X2) MULTIPLI A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2023		
	PROVIDER OR SUPPLIER	D NURSING FACILITY, THE	STRE 317 PER		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION
				Administrator	
K 0000					
Bldg. 01	Licensure Survey w Department of Heal	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000	29 September 2023	
	483.90(a). Survey Date: 09/14 Facility Number: 0 Provider Number: 1 AIM Number: 1002	00014 55039		Indiana State Departmen Health Attn: Brenda Buroker, Dir Long Term Care 2 North Meridian Street Indianapolis, In 46204	
	Peru Skilled Nursin compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one story facility Type II000 construction in the correction in the correction and batter the resident sleeping	Code survey, The Waters of g Facility was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, eSC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ction and was fully sprinklered. The alarm system with smoke ridors, areas open to the y powered smoke detection in grooms. The facility has a had a census of 38 at the time		RE: Survey Event ID NO Dear Ms. Buroker, Please accept the enclos of correction as a credible allegation of compliance deficiencies cited during Safety Survey conducted 14, 2023 at Water's of P latest date of compliance September 27, 2023. Hopefully you will find the remedies are sufficient. In of Peru is respectfully recepaper compliance.	sed plan e to the our Life I on Sept eru. Our will be at our
	access were sprinkle facility services were	residents have customary ered. All areas providing re sprinklered.		If after reviewing our plar correction, you have querequire further information do not hesitate to call me convenience at 765-473-	stions or n, please at your

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		(X2) MULTIPL A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2023		
	PROVIDER OR SUPPLIE	R ED NURSING FACILITY, THE	317	EET ADDRESS, CITY, STATE, ZIP C BLAIR PIKE RU, IN 46970	OD
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE A	HOULD BE COMPLETION
K 0100 SS=E Bldg. 01	NFPA 101 General Requirer General Requirer List in the REMA Section 18.1 and that are not addre K-tags, but are de along with the ap NFPA standard of on Form CMS-25 Based on observatifailed to maintain a smoke barrier door life safety features required by the Coremoved. This defi and up to 15 reside Findings include: Based on observation Director (MD) on a smoke barrier door with latching hards latch when tested. of observation, the to Fire Zone 13 we devices, but the do latch when tested. The finding was re	ments - Other RKS section any LSC 19.1 General Requirements essed by the provided eficient. This information, plicable Life Safety Code or itation, should be included 67. Ion and interview, the facility atching hardware on 1 of 7 es. LSC 4.6.12.3 requires existing obvious to the public if not de, shall be either maintained or cient practice could affect staff ents. Ion with the Maintenance 199/14/23 at 02:55 p.m., the set of es to Fire Zone 13 were provided ware but failed to close and Based on interview at the time MD agreed the smoke doors are equipped with latching ors did not properly close and viewed with the Administrator	K 0100	Sincerely, Debbie Coppernoll, HF Administrator K100 - It is the intent of to ensure to maintain la hardware on smoke batto meet set standards. 1 CORRECTIVE ATTAKEN: a On9/15/23 the Missupervisor/designee meto the latching hardware of smoke barrier doors Zone 13 to ensure it fur and latches into the fraset standards. The Adverified the work on 9/12 ALL OTHERS WEDTENTIAL TO BE All a All residents and and visitors have the pube affected but none we 9/15/23 the Maintenan Supervisor/designee in	f the facility atching arrier doors CTIONS aintenance nade repairs re on the set to Fire lly closes are to meet ministrator 18/23. ITH FFECTED: all staff otential to were. On ce aspected all
	and MD during the 3.1-19(b)	exit conference.		corridor doors through facility and found no ot findings.	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/14/2023
	ROVIDER OR SUPPLIER		317 B	F ADDRESS, CITY, STATE, ZIP COD LAIR PIKE	
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE	PERU	I, IN 46970	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	ATION TAG DEFICIENCY)		DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	3 MEASURES TO PREVEREOCCURRENCE: a On 9/27/23 the Administrator in-serviced the Maintenance Supervisor/desion the requirement that smoke barrier doors must fully self-cland latch into the frame to me set standards. b Maintenance Supervisor/designee will inspeall smoke barrier doors through the facility weekly to ensure the fully self-close and latch into the frame as a part of the facility's Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they ware 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. d. There is a video we can entire door is latching, howe the video is too large to uploat the portal. 4 MONITORING CORRECTIVE ACTION: a The inspection results (Attachment A) will be present	gnee e ose eet ect ghout ney he s gram on / rill be ce ew mail, noke ver, d to
			1	by the Maintenance	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>01</u>			COMPLETED	
		155039	B. WIN	IG		09/14/	2023	
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER				AIR PIKE			
WATERS	OF PERU SKILLE	D NURSING FACILITY, THE			IN 46970			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			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 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 9/27/23.	nlly ce by n is		

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155039	B. W	ING		09/14/2023		
NAME OF S	DDOMDED OF CLIEBY IS			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF I	PROVIDER OR SUPPLIEI	X.		317 BL	AIR PIKE			
WATERS	S OF PERU SKILLE	ED NURSING FACILITY, THE		PERU,	IN 46970			
(X4) ID		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	
	19.3.2.1, 19.3.5.9							
	Area Separation a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter d. Soiled Linen Re gallons) e. Trash Collection (exceeding 64 ga f. Combustible St (over 50 square fe g. Laboratories (if Hazard - see K32 Based on observati failed to ensure 1 of amounts of combus 50 square feet was	Automatic Sprinkler N/A I-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64 In Rooms Illons) orage Rooms/Spaces eet) classified as Severe	K 0	321	K321– It is the intent of the fa to ensure storage rooms with amounts of combustible stora and greater than 50 square for are protected as a hazardous to meet set standards. 1 CORRECTIVE ACTION TAKEN:	large ge eet area	09/27/2023	
	Based on observati with the Maintenan at 01:35 p.m., Activ boxes of supplies a feet making this a h room was not prote because the corridor close and latch who at the time of obser storage room conta combustible storage feet, and the corridor self-close and latch. The finding was re-	on during a tour of the facility to Director (MD) on 09/14/23 wity room contained over 20 and was greater than 50 square to the storage to the storage of door to the room did not self to tested. Based on interview to the MD agreed the sined large amount of the total to the room did not self to the storage than 50 square to the room did not self to the will be the storage than 50 square to the room did not to the room did not to the total to the total to the storage than 50 square to the room did not to the total tota			a On 9/25/23 the Mainten Supervisor/designee removed the boxes of supplies from the Activity Room to meet set standards. The Administrator verified the work on 9/25/23. Activity Room doo made repairs on the self-closi door to the activity room on 9/15/23. Administrator verifie 9/18/23. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all staff and visitors have the potentia be affected but none were. O 9/15/23 the Maintenance	d all r ng d on ED: f		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE C A. BUILDING B. WING	O1	-	ESURVEY LETED 1/2023
	PROVIDER OR SUPPLIE	RED NURSING FACILITY, THE	317 BI	ADDRESS, CITY, STATE, ZIP CO LAIR PIKE , IN 46970	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE
	3.1-19(b)			Supervisor/designee inshazardous area doors for combustible storage and other negative findings. 3 MEASURES TO PI REOCCURRENCE: a On 9/27/23 the Administrator in-serviced Maintenance Supervisor/designee/all the requirement to ensurare no combustible storates beyond the 50 square fest standards. b Maintenance Supervisor/designee will all hazardous areas to est there are no combustible items beyond the 50 squas a part of the facility's Maintenance Program a document those inspectives as appropriate. If any is discovered, they will be and resolved immediate Maintenance Supervisor will review with the Admithe inspection results. c The Administrator monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance of the Prev	d found no REVENT d the staff on re there age items eet to meet l inspect nsure e storage uare feet Preventive nd ion results ssues are addressed ly. The r/designee inistrator will e ce ie ce i	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
		155039	B. WI	NG		09/14/	2023
WATERS		D NURSING FACILITY, THE	•	317 BLA PERU, I	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970		(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	Maintenance and Testing Maintenance and Testing and Maintenance and Testing ar and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available. system last checked			4 MONITORING CORRECTIVE ACTION: a The inspection results (attachment A)will be presented by the Maintenance 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 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 9/27/23.	nly ce oy n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155039 B. WING 09/14/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 317 BLAIR PIKE WATERS OF PERU SKILLED NURSING FACILITY, THE PERU. IN 46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Based on observation and interview, the facility K 0353 K353 – It is the intent of the 09/27/2023 failed to ensure 1 of 1 sprinkler systems were facility to ensure sprinkler provided with spare sprinklers, a spare sprinkler systems are provided with spare cabinet and a sprinkler wrench on the premises. sprinklers, a spare sprinkler NFPA 25, Standard for the Inspection, Testing, cabinet and a sprinkler wrench on and Maintenance of Water-Based Fire Protection the premises to meet set Systems, 2011 Edition, Section 5.4.1.4 states a standards. supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been 1.CORRECTIVE ACTIONS operated or damaged in any way can be promptly TAKEN: replaced. The sprinklers shall correspond to the 1.On 9/21/23 the types and temperature ratings of the sprinklers on Maintenance Supervisor/designee the property. The sprinklers shall be kept in a installed a sprinkler cabinet so cabinet located where the temperature in which each of the 4 spare sprinklers they are subjected will at no time exceed 100 would have it's own protected slot degrees Fahrenheit. A special sprinkler wrench to meet set standards. The shall be provided and kept in the cabinet to be Administrator verified the work on used in the removal and installation of sprinklers. 9/21/23. This deficient practice could affect all residents 2.ALL OTHERS WITH and staff in the facility. POTENTIAL TO BE AFFECTED: 1.All residents and all staff and visitors have the potential to Findings include: be affected but none were. **3.MEASURES TO PREVENT** Based on observations during a tour of the facility with the Maintenance Director on 09/14/23 at REOCCURRENCE: 01:15 p.m. there were 2 spare sprinkler cabinets in 1.On 9/27/23 the the riser room that included 6 spare sprinklers in Administrator in-serviced the each cabinet in their own protective slot with an Maintenance Supervisor/designee additional 4 spare sprinklers that were not in their on the requirement that the own protected slot, being stored in the bottom of sprinkler system must be properly one of the sprinkler cabinets. Based on interview maintained including all spare at the time of the observation, the Maintenance sprinklers to be in their own Director agreed one of the spare sprinkler cabinets protective slot to meet set had 4 spare sprinklers not in protected slots. standards.

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	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 09/14	LETED
	PROVIDER OR SUPPLIE	R ED NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP C AIR PIKE IN 46970	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
		eviewed with the Administrator Director at the exit conference.		2.Maintenance Supervisor/designee we the sprinkler systems as with spare sprinkler he secured in their own proposed sides as a part of the fareventive Maintenance and document those in results as appropriate. issues are discovered, addressed and resolve immediately. The Maintenance supervisor/designee we with the Administrator inspection results. 3.The Administrator monitor adherence to the Preventative Maintenance schedule and validate and v	are provided ands rotective acility's ce Program aspection If any they will be ad antenance will review the ace. The area of the and the ent	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155039	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/14/2023
	PROVIDER OR SUPPLIEF	D NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970	
(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 IS CROSS-REFERENCED TO THE APPROP	(X5) COMPLETION DATE
				constitutes our credible allegation of compliance wall regulatory requirements. Our date of compliance is 9/27/23.	
K 0363 SS=E Bldg. 01	than required encexits, or hazardou of smoke and are solid-bonded corecapable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary and standard standard shadows covering is not expected and some covering is not expected. There is closing of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.1 frames shall be la other materials in unless the smoke sprinklered. Fixed	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2023		
	PROVIDER OR SUPPLIER	D NURSING FACILITY, THE	317 BL	ADDRESS, CITY, STATE, ZIP COD AIR PIKE IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	resistance of glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARI fire protection rati devices, etc. Based on observati failed to ensure 1 ca a means suitable fo no impediment to ca resist the passage of practice could affect resident room 36. Findings include: Based on observati Director (MD) on 0 corridor door to res not close into the fi privacy curtain was Based on interview MD agreed the corr not close into the de curtain was an imperior	viewed with the Administrator	K 0363	K363 – It is the intent of the facility to ensure corridor doors provided with a means suitable keeping the door closed, has n impediment to closing, latching and will resist the passage of smoke to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 9/18/23 the Maintena Supervisor/designee repaired to privacy curtain to resident sleer room 36 so the door would close and latch fully into the frame to meet set standards. The Administrator verified the work 9/18/23. 2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE and Visitors have the potential be affected but none were. The Maintenance Supervisor/designing inspected all corridor doors to ensure they latch fully into the frame and have no obstructions closing and found no other negative findings. 3 MEASURES TO PREVENCE:	e for no grant of the ping se of the

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On 9/27/23 the

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155039			A. BU	A. BUILDING <u>01</u> B. WING		COMPLETED 09/14/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF PERU SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 317 BLAIR PIKE PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE		COMPLETION
					Administrator in-serviced the Maintenance Supervisor/design and all staff on the requirement that corridor doors must latche into the frame and have no obstructions to closing to meeset standards. b Maintenance Supervisor/designee will inspending the maintenance of the facility monthly to ensure they latch fully into the frame and hone obstructions to closing as a part of 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/design will review with the Administrating 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 (Attachment A) of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/23.	at fully t cct ne ave sults are ssed e inee tor	

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