STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PERU SKILLED NURSING FACILITY, THE	317 BLAIR PIKE PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/14/23 Facility Number: 000014 Provider Number: 155039 AIM Number: 100288670 At this Emergency Preparedness survey, The Waters of Peru Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 130 and had a census of 38 at the time of this survey. Quality Review completed on 09/18/23	E 0000	29 September 2023 Indiana State Department of Health Attn: Brenda Buroker, Director of Long Term Care 2 North Meridian Street Indianapolis, In 46204 RE: Survey Event ID NQN921 Dear Ms. Buroker, Please accept the enclosed plan of correction as a credible allegation of compliance to the deficiencies cited during our Life Safety Survey conducted on Sept 14, 2023 at Water's of Peru. Our latest date of compliance will be September 27, 2023. Hopefully you will find that our remedies are sufficient. Water's of Peru is respectfully requesting paper compliance. If after reviewing our plan of correction, you have questions or require further information, please do not hesitate to call me at your convenience at 765-473-4426. Sincerely, Debbie Coppernoll, HFA	

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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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/14/2023 Facility Number: 000014 Provider Number: 155039 AIM Number: 100288670 At this Life Safety Code survey, The Waters of Peru Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II000 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detection in the resident sleeping rooms. The facility has a capacity of 130 and had a census of 38 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/18/23	K 0000	Administrator 29 September 2023 Indiana State Department of Health Attn: Brenda Buroker, Director of Long Term Care 2 North Meridian Street Indianapolis, In 46204 RE: Survey Event ID NQN921 Dear Ms. Buroker, Please accept the enclosed plan of correction as a credible allegation of compliance to the deficiencies cited during our Life Safety Survey conducted on Sept 14, 2023 at Water's of Peru. Our latest date of compliance will be September 27, 2023. Hopefully you will find that our remedies are sufficient. Water's of Peru is respectfully requesting paper compliance. If after reviewing our plan of correction, you have questions or require further information, please do not hesitate to call me at your convenience at 765-473-4426.	

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			Sincerely, Debbie Coppernoll, HFA Administrator	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 7 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and up to 15 residents. Findings include: Based on observation with the Maintenance Director (MD) on 09/14/23 at 02:55 p.m., the set of smoke barrier doors to Fire Zone 13 were provided with latching hardware but failed to close and latch when tested. Based on interview at the time of observation, the MD agreed the smoke doors to Fire Zone 13 were equipped with latching devices, but the doors did not properly close and latch when tested. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)	K 0100	**K100 -** It is the intent of the facility to ensure to maintain latching hardware on smoke barrier doors to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On**9/15/23** the Maintenance Supervisor/designee made repairs to the latching hardware on the set of smoke barrier doors to Fire Zone 13 to ensure it fully closes and latches into the frame to meet set standards. The Administrator verified the work on 9/18/23. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 9/15/23 the Maintenance Supervisor/designee inspected all corridor doors throughout the facility and found no other negative findings.	09/27/2023

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			3 **MEASURES TO PREVENT REOCCURRENCE**: a On 9/27/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that smoke barrier doors must fully self-close and latch into the frame to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility weekly to ensure they fully self-close and latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. d. There is a video we can email, if need be, proving that the smoke barrier door is latching, however, the video is too large to upload to the portal. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results (Attachment A) will be presented by the Maintenance	

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			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/23.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

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	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) on 09/14/23 at 01:35 p.m., Activity room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the MD agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room did not self-close and latch when tested. The finding was reviewed with the Administrator and the MD during the exit conference.	K 0321	**K321**– It is the intent of the facility to ensure storage rooms with large amounts of combustible storage and greater than 50 square feet are protected as a hazardous area to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 9/25/23 the Maintenance Supervisor/designee removed all the boxes of supplies from the Activity Room to meet set standards. The Administrator verified the work on 9/ 25/23. Activity Room door made repairs on the self-closing door to the activity room on 9/15/23. Administrator verified on 9/18/23. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 9/15/23 the Maintenance	09/27/2023

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	3.1-19(b)		Supervisor/designee inspected all hazardous area doors for combustible storage and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 9/27/23 the Administrator in-serviced the Maintenance Supervisor/designee/all staff on the requirement to ensure there are no combustible storage items beyond the 50 square feet to meet set standards. b Maintenance Supervisor/designee will inspect all hazardous areas to ensure there are no combustible storage items beyond the 50 square feet as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. d. There is a video that we can email, if need be, proving that the door is now self latching. However, we could not upload it as the video is too large to upload to the portal.	

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			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 monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/23.**	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	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 failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/14/23 at 01:15 p.m. there were 2 spare sprinkler cabinets in the riser room that included 6 spare sprinklers in each cabinet in their own protective slot with an additional 4 spare sprinklers that were not in their own protected slot, being stored in the bottom of one of the sprinkler cabinets. Based on interview at the time of the observation, the Maintenance Director agreed one of the spare sprinkler cabinets had 4 spare sprinklers not in protected slots.	K 0353	**K353** – It is the intent of the facility to ensure sprinkler systems are provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 9/21/23 the Maintenance Supervisor/designee installed a sprinkler cabinet so each of the 4 spare sprinklers would have it's own protected slot to meet set standards. The Administrator verified the work on 9/21/23 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 9/27/23 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained including all spare sprinklers to be in their own protective slot to meet set standards.	09/27/2023

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		2.Maintenance Supervisor/designee will ensure the sprinkler systems are provided with spare sprinkler heads secured in their own protective slots as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results (attachment A) will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/23.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments			

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	there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 8 residents in the vicinity of resident room 36. Findings include: Based on observation with the Maintenance Director (MD) on 09/14/23 at 02:00 p.m., the corridor door to resident sleeping room 36 would not close into the frame when tested because the privacy curtain was an impediment to closing. Based on interview at the time of observation, the MD agreed the corridor door to room 36 would not close into the door frame because the privacy curtain was an impediment to closing. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)	K 0363	**K363** – It is the intent of the facility to ensure corridor doors are provided with a means suitable for keeping the door closed, has no 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 Maintenance Supervisor/designee repaired the privacy curtain to resident sleeping room 36 so the door would close and latch fully into the frame to meet set standards. The Administrator verified the work on 9/18/23. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they latch fully into the frame and have no obstructions to closing and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 9/27/23 the	09/27/2023

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			Administrator in-serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors must latch fully into the frame and have no obstructions to closing to meet set standards. b Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they latch fully into the frame and have no obstructions to closing as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results (Attachment A) **of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/27/23.**	