STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 01 B. WING	10/26/2023

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/14/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 10/26/23 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 the Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a). The facility has 130 certified beds. At the time of survey the census was 35. Quality Review completed on 10/30/23	K 0000	7 November 2023 **Indiana State Department of HealthAttn: Brenda Buroker, Director of Long Term Care2 North Meridian StreetIndianapolis, 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 October 26, 2023 at Water's of Peru. Our latest date of compliance will be November 6, 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, HFAAdministrator**	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Coppernoll	Administrator	11/07/2023

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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	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 30 residents. Findings include: Based on observation with the Maintenance Director (MD) on 10/26/23 at 02:15 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 were equipped with latching devices, but the doors did not properly close and latch when tested. This deficiency was cited on 09/14/23. The facility failed to implement a systemic plan of correction to prevent recurrence. The finding was reviewed with the 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 10/26/23 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 10/27/23 . 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 10/27/23 the Maintenance Supervisor/designee inspected all corridor doors throughout the facility and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10/27/23 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.	11/06/2023

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			b Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility daily (Monday-Friday) using Attachment A for six weeks then change to 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. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/6/23	