| STATEMEN   | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059  |        | JILDING<br>NG | ONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>08/03/2023 |                    |
|--|--|--|--------|---------------|---|---|--------------------|
|  | PROVIDER OR SUPPLIER<br>S OF HUNTINGTON  | R<br>N SKILLED NURSING FACILITY, T                       | THE    | 1500 G        | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750   |   |                    |
| (X4) ID<br>PREFIX  |  | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL |        | ID<br>PREFIX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR | IATE  | (X5)<br>COMPLETION |
| TAG  | REGULATORY OF  | R LSC IDENTIFYING INFORMATION                            |        | TAG           | DEFICIENCY)   |   | 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: 08/03/23  Facility Number: 000020 Provider Number: 155059 AIM Number: 100288696  At this Emergency Preparedness survey, The Waters of Huntington Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 85 and had a census of 45 at the time of this survey.  Quality Review completed on 08/08/23 |  | E 0000 |               |   |   |                    |
| Quality Review completed on 08/08/23  403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)  EP Testing Requirements \$416.54(d)(2), \$481.113(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$482.15(d)(2), \$483.73(d)(2), \$483.475(d)(2), \$484.102(d)(2), \$485.68(d)(2), \$485.625(d)(2), \$485.727(d)(2), \$485.920(d) (2), \$491.12(d)(2), \$494.62(d)(2).  *[For ASCs at \$416.54, CORFs at \$485.68, OPO, "Organizations" under \$485.727, CMHCs at \$485.920, RHCs/FQHCs at \$491.12, and ESRD Facilities at \$494.62]: |  |  |        |               |   |   |                    |

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

TITLE (X6) DATE

Bryce Tomasi Administrator 08/23/2023

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.

Event ID: ONW021 Facility ID: If continuation sheet

PRINTED: 08/25/2023

|                          |  |   |      |                     | DEPARTMENT OF HEALTH AND HUMAN SERVICES  ENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (AND PLAN OF CORRECTION IDENTIFICATION NUMBER (A. BUILDING B. WING |          |                                 |  |  |  |  |  |  |  |
|--------------------------|--|---|------|---------------------|--|----------|---------------------------------|--|--|--|--|--|--|--|
|                          |  | IDENTIFICATION NUMBER   | A. B | UILDING             | ONSTRUCTION  | CON      | TE SURVEY<br>MPLETED<br>03/2023 |  |  |  |  |  |  |  |
|                          | PROVIDER OR SUPPLIE  | R<br>N SKILLED NURSING FACILITY   | THE  | 1500 G              | ADDRESS, CITY, STATE, ZIP C<br>RANT ST<br>NGTON, IN 46750  | OD       |                                 |  |  |  |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (2) Testing. The [facility] must conduct exercises to test the emergency plan   |   |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | HOULD BE | (X5) COMPLETION DATE            |  |  |  |  |  |  |  |
|                          | annually. The [faction following:  | cility] must do all of the  |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          | community-based (A) When a com not accessible, co functional exercis (B) If the [fac   | d every 2 years; or<br>munity-based exercise is<br>onduct a facility-based<br>se every 2 years; or<br>cility] experiences an actual |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          | natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.  (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)  (i) of this section is conducted, that may include, but is not limited to the following: |   |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          |  |   |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          | community-based<br>functional exercis<br>(B) A mock disas<br>(C) A tabletop ex   | ter drill; or<br>ercise or workshop that is   |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          | discussion using<br>clinically-relevant<br>set of problem sta<br>messages, or pre  | emergency scenario, and a<br>atements, directed<br>epared questions designed  |      |                     |  |          |                                 |  |  |  |  |  |  |  |
|                          | maintain docume  | emergency plan.  facility's] response to and entation of all drills, tabletop mergency events, and revise                           |      |                     |  |          |                                 |  |  |  |  |  |  |  |

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the [facility's] emergency plan, as needed.

\*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in

Event ID:

 $ONW021 \quad \text{Facility ID:} \quad 000020$ 

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| STATEMEN  | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA                                 | (X2) M | ULTIPLE CC | ONSTRUCTION  | (X3) DATE SURVEY |            |  |
|-----------|---|--|--------|------------|--|------------------|------------|--|
| AND PLAN  | OF CORRECTION   | IDENTIFICATION NUMBER                                      |        | JILDING    | <del></del>  | COMPI            |            |  |
|           |   | 155059   | B. W   | ING        |  | 08/03            | /2023      |  |
| NAME OF I | PROVIDER OR SUPPLIER  |  | •      | STREET A   | ADDRESS, CITY, STATE, ZIP COD  |                  |            |  |
|           |   |  |        | 1500 G     | RANT ST  |                  |            |  |
| WATERS    | S OF HUNTINGTON   | N SKILLED NURSING FACILITY, 1                              | THE    | HUNTIN     | NGTON, IN 46750  |                  |            |  |
| (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<br>CROSS-REFERENCED TO THE APPROPR | IATE             | COMPLETION |  |
| TAG       |   | R LSC IDENTIFYING INFORMATION                              | +      | TAG        | DEFICIENCY)  |                  | DATE       |  |
|           |   | e. The hospice must  |        |            |  |                  |            |  |
|           |   | s to test the emergency                                    |        |            |  |                  |            |  |
|           | 1 3   | plan at least annually. The hospice must do the following: |        |            |  |                  |            |  |
|           | (i) Participate in a full-scale exercise that is community based every 2 years; or    |  |        |            |  |                  |            |  |
|           |   |  |        |            |  |                  |            |  |
|           | 1   |  |        |            |  |                  |            |  |
|           |   | nunity based exercise is not                               |        |            |  |                  |            |  |
|           |   | ict an individual facility<br>exercise every 2 years; or   |        |            |  |                  |            |  |
|           |   | exercise every 2 years; or experiences a natural or        |        |            |  |                  |            |  |
|           | . ,   | experiences a natural of<br>lency that requires activation |        |            |  |                  |            |  |
|           |   | •  |        |            |  |                  |            |  |
|           | of the emergency plan, the hospital is exempt from engaging in its next required full |  |        |            |  |                  |            |  |
|           |   | based exercise or individual                               |        |            |  |                  |            |  |
|           | 1   | ctional exercise following the                             |        |            |  |                  |            |  |
|           | onset of the emer   | _  |        |            |  |                  |            |  |
|           |   | dditional exercise every 2                                 |        |            |  |                  |            |  |
|           | · '   | e year the full-scale or                                   |        |            |  |                  |            |  |
|           |   | e under paragraph (d)(2)(i)                                |        |            |  |                  |            |  |
|           |   | conducted, that may  |        |            |  |                  |            |  |
|           |   | limited to the following:                                  |        |            |  |                  |            |  |
|           |   | -scale exercise that is                                    |        |            |  |                  |            |  |
|           |   | l or a facility based                                      |        |            |  |                  |            |  |
|           | functional exercise   | -  |        |            |  |                  |            |  |
|           | (B) A mock disas  |  |        |            |  |                  |            |  |
|           |   | ercise or workshop that is                                 |        |            |  |                  |            |  |
|           | . , ,   | and includes a group                                       |        |            |  |                  |            |  |
|           | discussion using a  |  |        |            |  |                  |            |  |
|           | _   | emergency scenario, and a                                  |        |            |  |                  |            |  |
|           | set of problem sta  | tements, directed  |        |            |  |                  |            |  |
|           | messages, or pre  | pared questions designed                                   |        |            |  |                  |            |  |
|           | to challenge an er  | mergency plan.   |        |            |  |                  |            |  |
|           | (3) Testing for hos   | spices that provide inpatient                              |        |            |  |                  |            |  |
|           | ` '   | hospice must conduct                                       |        |            |  |                  |            |  |
|           |   | he emergency plan twice                                    |        |            |  |                  |            |  |
|           |   | spice must do the following:                               |        |            |  |                  |            |  |
|           |   | an annual full-scale exercise                              |        |            |  |                  |            |  |
|           | ' '   |  |        |            |  |                  |            |  |
|           | that is community-based; or  (A) When a community-based exercise is not               |  |        |            |  |                  |            |  |

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| STATEMEN                                | EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA   | (X2) M                                      | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY  |       |            |
|---|--|---|------------|------------|---|-------|------------|
| AND PLAN                                | OF CORRECTION  | IDENTIFICATION NUMBER                       | A. B       | UILDING    | <u></u>   | COMPL | LETED      |
|   |  | 155059                                      | B. W       | ING        |   | 08/03 | /2023      |
|   |  |   |            | STREET A   | ADDRESS, CITY, STATE, ZIP COD   |       |            |
| NAME OF I                               | PROVIDER OR SUPPLIE  | R   |            |            | RANT ST   |       |            |
| WATER!                                  | S OF HUNTINGTO   | N SKILLED NURSING FACILITY,                 | THE        |            | NGTON, IN 46750   |       |            |
| *************************************** |  | TOTALEED HOROITOTAGIETT,                    |            | 11011111   | 10700   |       | 1          |
| (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<br>CROSS-REFERENCED TO THE APPROPRI | ATE   | COMPLETION |
| TAG                                     |  | R LSC IDENTIFYING INFORMATION               |            | TAG        | DEFICIENCY)   |       | DATE       |
|   |  | uct an annual individual                    |            |            |   |       |            |
|   | -  | ctional exercise; or                        |            |            |   |       |            |
|   |  | experiences a natural or                    |            |            |   |       |            |
|   |  | man-made emergency that requires activation |            |            |   |       |            |
|   |  | plan, the hospice is                        |            |            |   |       |            |
|   |  | aging in its next required                  |            |            |   |       |            |
|   |  | nity based or facility-based                |            |            |   |       |            |
|   |  | e following the onset of the                |            |            |   |       |            |
|   | emergency event  | dditional annual exercise                   |            |            |   |       |            |
|   | , ,  |   |            |            |   |       |            |
|   | that may include, but is not limited to the  |   |            |            |   |       |            |
|   | following:  (A) A second full-scale exercise that is community-based or a facility based |   |            |            |   |       |            |
|   |  |   |            |            |   |       |            |
|   | functional exercis   |   |            |            |   |       |            |
|   | (B) A mock disas   |   |            |            |   |       |            |
|   |  | ercise or workshop led by a                 |            |            |   |       |            |
|   | 1 ' '  | udes a group discussion                     |            |            |   |       |            |
|   |  | clinically-relevant                         |            |            |   |       |            |
|   | 1 -  | ario, and a set of problem                  |            |            |   |       |            |
|   |  | ted messages, or prepared                   |            |            |   |       |            |
|   |  | ed to challenge an                          |            |            |   |       |            |
|   | emergency plan.  | ŭ   |            |            |   |       |            |
|   |  | nospice's response to and                   |            |            |   |       |            |
|   | maintain docume  | ntation of all drills, tabletop             |            |            |   |       |            |
|   | exercises, and en  | nergency events and revise                  |            |            |   |       |            |
|   | the hospice's eme  | ergency plan, as needed.                    |            |            |   |       |            |
|   |  |   |            |            |   |       |            |
|   |  |   |            |            |   |       |            |
|   |  | 441.184(d), Hospitals at                    |            |            |   |       |            |
|   | §482.15(d), CAH  | - ' ' -                                     |            |            |   |       |            |
|   | 1 ' '  | PRTF, Hospital, CAH] must                   |            |            |   |       |            |
|   |  | s to test the emergency                     |            |            |   |       |            |
|   |  | ar. The [PRTF, Hospital,                    |            |            |   |       |            |
|   | CAH] must do the   |   |            |            |   |       |            |
|   |  | an annual full-scale exercise               |            |            |   |       |            |
|   | that is community  |   |            |            |   |       |            |
|   |  | nunity-based exercise is not                |            |            |   |       |            |
|   |  | uct an annual individual,                   |            |            |   |       |            |
|   | facility-based functional exercise; or   |   |            |            |   |       |            |

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| STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059   | A. B  | MULTIPLE CO<br>UILDING<br>/ING | ONSTRUCTION   | COMI   | (X3) DATE SURVEY COMPLETED 08/03/2023 |  |  |
|--------------------------|--|---|-------|--------------------------------|---|--------|---------------------------------------|--|--|
|                          | PROVIDER OR SUPPLIER   | R SKILLED NURSING FACILITY  | , THE | 1500 G                         | ADDRESS, CITY, STATE, ZIP CO<br>RANT ST<br>NGTON, IN 46750  | D      |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |       | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE            |  |  |
|                          | (B) If the [PRTF, I an actual natural of that requires active plan, the [facility] its next required from individual, facility following the onset (ii) Conduct a exercise or and the limited to the follotom (A) A second full-community-based facility-based function (B) A more (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an erection (iii) Analyze the and maintain doct tableton exercises and revise the [facineeded.  *[For PACE at §44 (2) Testing. The Form conduct exercises plan at least annuorganization mustiful (i) Participate in a that is community (A) When a community (A) When a community (A) When a community (B) that is community (B) that | Hospital, CAH] experiences or man-made emergency ration of the emergency is exempt from engaging in cull-scale community based ity-based functional exercise et of the emergency event. It is an [additional] annual mat may include, but is not wing:  -scale exercise that is a crional exercise; or cock disaster drill; or cock disaster drill; or cock disaster drill; or cock emergency scenario, and a stements, directed pared questions designed mergency plan.  The [facility's] response to cumentation of all drills, is, and emergency events collity's] emergency plan, as  60.84(d):]  PACE organization must is to test the emergency exercise or exercise in annual full-scale exercise. |       |                                |   |        |                                       |  |  |

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activation of the emergency plan, the PACE

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

|                          | OF CORRECTION  | IDENTIFICATION NUMBER  155059   | r / | JILDING             | nstruction<br>  | COMPLETED 08/03/2023 |                            |
|--------------------------|--|---|-----|---------------------|---|----------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER   | SKILLED NURSING FACILITY, T   | HE  | 1500 GF             | DDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>IGTON, IN 46750  |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | тЕ                   | (X5)<br>COMPLETION<br>DATE |
|                          | full-scale community-based functional exercises of this section is cobut is not limited to (A) A second full-community-based based functional exercises of this section is cobut is not limited to (A) A second full-community-based based functional exercises (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an erection (iii) Analyze the Problem star messages, and emeter exercises, and emeter exercises (2) The [LTC facilities (2) The [LTC facilities (2) The [LTC facilities (3) The including unstable emergency problem in a that is community-(A) When a community-(A) When a community-(B) If the [LTC facility-based function in the including inc | n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed nergency plan. ACE's response to and station of all drills, tabletop tergency events and revise gency plan, as needed.  s at §483.73(d):] ty] must conduct exercises ncy plan at least twice per announced staff drills using poedures. The [LTC facility, me following: n annual full-scale exercise based; or unity-based exercise is not ct an annual individual, |     |                     |   |                      |                            |

|           | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  | l í   |      | ONSTRUCTION | (X3) DATE SURVEY  |        |            |
|-----------|---|---|------|-------------|---|--------|------------|
| AND PLAN  | OF CORRECTION   | IDENTIFICATION NUMBER                           |      | UILDING     | <del></del>   | COMPL  |            |
|           |   | 155059  | B. W | 'ING        |   | 08/03/ | 2023       |
| NAME OF P | PROVIDER OR SUPPLIER  |   |      |             | ADDRESS, CITY, STATE, ZIP COD   |        |            |
|           |   |   | TUE  |             | RANT ST   |        |            |
| WATERS    | OF HUNTINGTON   | SKILLED NURSING FACILITY,                       | IHE  | HUNIIN      | NGTON, IN 46750   |        |            |
| (X4) ID   |   | STATEMENT OF DEFICIENCIE                        |      | ID          | PROVIDER'S PLAN OF CORRECTION   |        | (X5)       |
| PREFIX    | `   | CY MUST BE PRECEDED BY FULL                     |      | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE    | COMPLETION |
| TAG       |   | LSC IDENTIFYING INFORMATION                     |      | TAG         | DEFICIENCY)   |        | DATE       |
|           |   | le community-based or based functional exercise |      |             |   |        |            |
|           | I -   | t of the emergency event.                       |      |             |   |        |            |
|           |   | dditional annual exercise                       |      |             |   |        |            |
|           | 1 ' '   | but is not limited to the                       |      |             |   |        |            |
|           | following:  | <del></del>                                     |      |             |   |        |            |
|           | <ul> <li>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</li> <li>(B) A mock disaster drill; or</li> <li>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated,</li> </ul> |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           | 1   | emergency scenario, and a                       |      |             |   |        |            |
|           | set of problem sta  |   |      |             |   |        |            |
|           | to challenge an er  | pared questions designed                        |      |             |   |        |            |
|           | _   | nergency plan.<br>_TC facility] facility's      |      |             |   |        |            |
|           |   | naintain documentation of                       |      |             |   |        |            |
|           |   | exercises, and emergency                        |      |             |   |        |            |
|           |   | e the [LTC facility] facility's                 |      |             |   |        |            |
|           | emergency plan, a   |   |      |             |   |        |            |
|           | J , , , , , ,   |   |      |             |   |        |            |
|           | *[For ICF/IIDs at §   | 3483.475(d)]:                                   |      |             |   |        |            |
|           | _ , ,   | CF/IID must conduct                             |      |             |   |        |            |
|           |   | he emergency plan at least                      |      |             |   |        |            |
|           |   | e ICF/IID must do the                           |      |             |   |        |            |
|           | following:  |   |      |             |   |        |            |
|           |   | n annual full-scale exercise                    |      |             |   |        |            |
|           | that is community-  |   |      |             |   |        |            |
|           | 1 ' '   | nunity-based exercise is not                    |      |             |   |        |            |
|           |   | ct an annual individual,                        |      |             |   |        |            |
|           | 1   | ctional exercise; or.<br>Experiences an actual  |      |             |   |        |            |
|           | l ` '   | ade emergency that requires                     |      |             |   |        |            |
|           |   | mergency plan, the ICF/IID                      |      |             |   |        |            |
|           |   |   |      |             |   |        |            |
|           | is exempt from engaging in its next required full-scale community-based or individual,  |   |      |             |   |        |            |
|           |   | -   |      |             |   |        |            |
|           | facility-based functional exercise following the  |   |      |             |   |        |            |

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|                   | NT OF DEFICIENCIES OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059 | I . | UILDING      | NSTRUCTION   | (X3) DATE SURVEY  COMPLETED  08/03/2023 |                    |  |
|-------------------|---|---|-----|--------------|--|---|--------------------|--|
|                   | PROVIDER OR SUPPLIE   | R<br>N SKILLED NURSING FACILITY,                        | THE | 1500 GI      | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750                                |   |                    |  |
| (X4) ID<br>PREFIX |   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL   |     | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO |   | (X5)<br>COMPLETION |  |
| TAG               | REGULATORY O  | R LSC IDENTIFYING INFORMATION                           |     | TAG          | DEFICIENCY)  |   | DATE               |  |
|                   | (ii) Conduct an ac  | dditional annual exercise                               |     |              |  |   |                    |  |
|                   | that may include, following:  | but is not limited to the                               |     |              |  |   |                    |  |
|                   | _   | scale exercise that is                                  |     |              |  |   |                    |  |
|                   | community-based or an individual,   |   |     |              |  |   |                    |  |
|                   | facility-based fund   | ctional exercise; or                                    |     |              |  |   |                    |  |
|                   | (B) A mock disast   | ter drill; or   |     |              |  |   |                    |  |
|                   | (C) A tabletop exe  | ercise or workshop that is                              |     |              |  |   |                    |  |
|                   |   | r and includes a group                                  |     |              |  |   |                    |  |
|                   | discussion, using   |   |     |              |  |   |                    |  |
|                   | clinically-relevant emergency scenario, and a<br>set of problem statements, directed<br>messages, or prepared questions designed<br>to challenge an emergency plan. |   |     |              |  |   |                    |  |
|                   |   |   |     |              |  |   |                    |  |
|                   |   |   |     |              |  |   |                    |  |
|                   |   |   |     |              |  |   |                    |  |
|                   |   | CF/IID's response to and                                |     |              |  |   |                    |  |
|                   |   | ntation of all drills, tabletop                         |     |              |  |   |                    |  |
|                   |   | mergency events, and revise                             |     |              |  |   |                    |  |
|                   | the ICF/IID's eme   | ergency plan, as needed.                                |     |              |  |   |                    |  |
|                   | *[For HHAs at §4  | =   |     |              |  |   |                    |  |
|                   |   | ne HHA must conduct                                     |     |              |  |   |                    |  |
|                   |   | the emergency plan at                                   |     |              |  |   |                    |  |
|                   |   | ne HHA must do the                                      |     |              |  |   |                    |  |
|                   | following:  |   |     |              |  |   |                    |  |
|                   |   | a full-scale exercise that is                           |     |              |  |   |                    |  |
|                   | community-based   |   |     |              |  |   |                    |  |
|                   | , ,   | community-based exercise conduct an annual              |     |              |  |   |                    |  |
|                   | ,   | -based functional exercise                              |     |              |  |   |                    |  |
|                   | every 2 years; or.  |   |     |              |  |   |                    |  |
|                   |   | łA experiences an actual                                |     |              |  |   |                    |  |
|                   | ` '   | ade emergency that requires                             |     |              |  |   |                    |  |
|                   |   | emergency plan, the HHA is                              |     |              |  |   |                    |  |
|                   |   | aging in its next required                              |     |              |  |   |                    |  |
|                   |   | nity-based or individual,                               |     |              |  |   |                    |  |
|                   |   | ctional exercise following the                          |     |              |  |   |                    |  |
|                   | onset of the emer   | _   |     |              |  |   |                    |  |
|                   | (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or  |   |     |              |  |   |                    |  |
|                   |   |   |     |              |  |   |                    |  |
|                   |   | se under paragraph (d)(2)(i)                            |     |              |  |   |                    |  |

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| AND PLAN OF CORRECTION   |   | IDENTIFICATION NUMBER  155059   |     | UILDING  TING   | .DING <u></u>   |  | SURVEY<br>ETED<br>/2023    |  |
|--------------------------|---|---|-----|---|---|--|----------------------------|--|
|                          | F PROVIDER OR SUPPLIER  | SKILLED NURSING FACILITY,   | THE | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HUNTINGTON, IN 46750 |   |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   |     | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |  |
|                          | (A) A second community-based facility-based function (B) A mock did (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem states ages, or present to challenge an error to challenge an error to challenge and error to | limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and station of all drills, tabletop sergency events, and revise ency plan, as needed.  36.360] e OPO must conduct she emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of sts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset |     |   |   |  |                            |  |

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| CENTERS FOI | ENTERS FOR MEDICARE & MEDICAID SERVICES  |   |       |   |   | OM  | IB NO. 0938-039               |  |
|-------------|--|---|-------|---|---|---|-------------------------------|--|
|             | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | ľ í   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                            |   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|             |  | 155059  |       |   |   |   | /2023                         |  |
|             | PROVIDER OR SUPPLIER   | SKILLED NURSING FACILITY  | , THE | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST THE HUNTINGTON, IN 46750 |   |   |                               |  |
| (X4) ID     | SUMMARY  | STATEMENT OF DEFICIENCIE  |       | ID  | PROVIDER'S PLAN OF CORRECTION   |   | (X5)                          |  |
| PREFIX      | ``   | CY MUST BE PRECEDED BY FULL   |       | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA   | ATE   | COMPLETION                    |  |
| TAG         | REGULATORY OF  | R LSC IDENTIFYING INFORMATION   |       | TAG   | DEFICIENCY)   |   | DATE                          |  |
|             | exercises to test to RNHCI must do the RNHCI must do the (i) Conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain documer exercises, and enter the RNHCI's emel Based on record restailed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community-based a. When a community facility-based funct b. If the LTC facility or man-made emergof the emergency promengaging its in community-based of the conset of the activation of the conset of th | e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility nercises to test the emergency er year, including drills using the emergency or facility must do the annual full-scale exercise that d; or ity-based exercise is not an annual individual, ional exercise. y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based I exercise for 1 year following table to the following: | E 0   | 039   | E039 – It is the intent of the facility to ensure to conduct exercises to test the emerger plan at least twice per year, including unannounced staff of using the emergency proceduto meet set standards.  1. CORRECTIVE ACTION TAKEN:  a. On 8/29/2023 the Administrator and the Maintenance Supervisor/desiconducted a community or facility-based annual exercise tabletop exercise and comple documentation for the exercise meet set standards.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. | drills ures  US  gnee e or ted se to  ED:  ff | 08/30/2023                    |  |

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functional exercise.

b. A mock disaster drill; or

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REOCCURRENCE:

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**MEASURES TO PREVENT** 

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|                          | IT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059  | A. B | MULTIPLE CO<br>BUILDING<br>VING | ONSTRUCTION  | (X3) DATE<br>COMPL<br>08/03/   | LETED                      |  |
|--------------------------|--|--|------|---------------------------------|--|--|----------------------------|--|
|                          | PROVIDER OR SUPPLIER   | N SKILLED NURSING FACILITY, T  | HE   | 1500 G                          | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750  |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  |      | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |  |
|                          | c. A tabletop exercifacilitator that incluan a narrated, clinically and a set of problem messages, or preparchallenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emeraccordance with 42 deficient practice of Findings include:  Based on record revision Maintenance Direct p.m., no documentate based annual exercises at the time stated the facility decrease and the facili | R LSC IDENTIFYING INFORMATION  Is a converted to the conv |      |                                 | a. On 8/15/2023 the Administrator inserviced the Maintenance Supervisor/designon the requirement that a community or facility-based exercise or tabletop exercise be conducted annually and documentation retained to me set standards. b. Maintenance Supervisor/designee will work the Administrator to ensure a community or facility-based exercise or tabletop exercise conducted and documented to meet set standards. If any issues are discovered, they waddressed and resolved immediately. c. The Administrator will monitor adherence to the Emergency Preparedness Polanual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to enscompliance, the Administrator Maintenance Supervisor/designing will review the Emergency Preparedness Policy Manual conduct required exercises ar make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrator present the training results at Quality Assurance/ Performar Improvement (QA/PI) meeting | gnee must eet with is o rill be licy sure and gnee and to s or will the nce g. |                            |  |
|                          |  |  | 1    |                                 | Results and system compone   | JUS  | 1                          |  |

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|                          | OF CORRECTION  | IDENTIFICATION NUMBER  155059   | A. BUILDING  B. WING  |  | COMPLETED 08/03/2023         |  |  |
|--------------------------|--|---|---|--|------------------------------|--|--|
|                          | ROVIDER OR SUPPLIER  | I SKILLED NURSING FACILITY, T   | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HUNTINGTON, IN 46750 |  |                              |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE         |  |  |
| K 0000                   |  |   |   | will be reviewed by the QA/PI Committee with subsequent p of correction developed and implemented as deemed necessary to ensure compliant is maintained.  This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.  Our date of compliance is 08/30/2023.   | ice                          |  |  |
|                          |  |   |   |  |                              |  |  |
| Bldg. 01                 | Licensure Survey w Department of Heal 483.90(a).  Survey Date: 08/03  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety Of Huntington Skilled in compliance with in Medicare/Medica Life Safety from Fir National Fire Protec Life Safety Code (L) Health Care Occupa | 200020 55059 88696 Code survey, The Waters of Nursing Facility was found not Requirements for Participation aid, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ection Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  ty was determined to be of | K 0000  | DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wi Federal Medicare and Medicaid requirements. | t<br>the<br>set<br>red<br>ce |  |  |
|                          | Type II 000 constructions and sprinklered. The factorial sprinklered.  |   |   |  |                              |  |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |          |  |        | SURVEY     |  |
|--|---|---|---|----------|--|--------|------------|--|
| AND PLAN (   | OF CORRECTION   | IDENTIFICATION NUMBER                               | A. BU                                       | ILDING   | 01   | COMPL  | COMPLETED  |  |
|  |   | 155059  | B. WI                                       | NG       | _  | 08/03/ | 2023       |  |
|  |   |   |   | STREET A | ADDRESS, CITY, STATE, ZIP COD  |        |            |  |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |   |          | RANT ST  |        |            |  |
| WATERS   | OF HUNTINGTON   | I SKILLED NURSING FACILITY, T                       | HE  | HUNTIN   | NGTON, IN 46750  |        |            |  |
| (X4) ID  |   | STATEMENT OF DEFICIENCIE                            |   | ID       | PROVIDER'S PLAN OF CORRECTION  |        | (X5)       |  |
| PREFIX   |   | CY MUST BE PRECEDED BY FULL                         |   | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |  |
| TAG  |   | LSC IDENTIFYING INFORMATION battery powered smoke   | -   | TAG      | DEFICIENCE   |        | DATE       |  |
|  |   | - 1   |   |          |  |        |            |  |
|  | detection in the resident sleeping rooms. The facility has a capacity of 85 and had a census of |   |   |          |  |        |            |  |
|  | 45 at the time of this  | - T   |   |          |  |        |            |  |
|  | 45 at the time of this  | s survey.   |   |          |  |        |            |  |
|  | All areas where the   | residents have customary                            |   |          |  |        |            |  |
|  |   | ered. All areas providing                           |   |          |  |        |            |  |
|  | facility services wer   | re sprinklered.                                     |   |          |  |        |            |  |
|  | Quality Review con  | npleted on 08/08/23                                 |   |          |  |        |            |  |
| K 0211   | NFPA 101  |   |   |          |  |        |            |  |
| SS=E   | Means of Egress -   | General   |   |          |  |        |            |  |
| Bldg. 01   | Means of Egress -   | General   |   |          |  |        |            |  |
|  | Aisles, passagewa   | ays, corridors, exit                                |   |          |  |        |            |  |
|  | discharges, exit lo   | cations, and accesses are                           |   |          |  |        |            |  |
|  | in accordance with  | n Chapter 7, and the means                          |   |          |  |        |            |  |
|  | -   | uously maintained free of                           |   |          |  |        |            |  |
|  | all obstructions to   |   |   |          |  |        |            |  |
|  |   | s modified by 18/19.2.2                             |   |          |  |        |            |  |
|  | through 18/19.2.1   |   |   |          |  |        |            |  |
|  | 18.2.1, 19.2.1, 7.1   |   |   |          |  |        |            |  |
|  |   | on and interview, the facility                      | K 02  | 211      | <b>K211</b> – It is the intent of the  |        | 08/04/2023 |  |
|  |   | 1 corridor means of egresses                        |   |          | facility to ensure corridor mear   | ns of  |            |  |
|  | were continuously n   | 9.2.3.4 (4) states projections                      |   |          | egress are continuously  | one    |            |  |
|  |   |   |   |          | maintained free of all obstructi   | ons    |            |  |
|  |   | dth shall be permitted for provided that all of the |   |          | to meet set standards.  1. CORRECTIVE ACTION   | 9      |            |  |
|  | following condition   |   |   |          | 1. CORRECTIVE ACTIONS TAKEN:   | ی      |            |  |
|  | -   | aipment does not reduce the                         |   |          | a. On 8/4/2023 the   |        |            |  |
|  |   | corridor width to less than 60                      |   |          | Maintenance Supervisor/desig   | ınee   |            |  |
|  | in.(1525 mm).   |   |   |          | added wheels to the cart to me   |        |            |  |
|  |   | occupancy fire safety plan and                      |   |          | set standards. The Administra  |        |            |  |
|  |   | dress the relocation of the                         |   |          | verified the work on 8/04/2023   |        |            |  |
|  |   | during a fire or similar                            |   |          | 2. ALL OTHERS WITH   |        |            |  |
|  | emergency.  |   |   |          | POTENTIAL TO BE AFFECTE  | ED:    |            |  |
|  | (c)The wheeled equ  | ipment is limited to the                            |   |          | a. All residents and all staf  | f      |            |  |
|  | following:  |   |   |          | and visitors have the potential  | to     |            |  |
|  | i. Equipment in use   | and carts in use                                    |   |          | be affected but none were. Or  | n      |            |  |
|  | ii Medical emergen  | cy equipment not in use                             | 1   |          | 8/4/2023 the Maintenance   |        |            |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | r í                            |         |          | · /  | X3) DATE SURVEY |            |  |
|--|--|--------------------------------|---------|----------|--|-----------------|------------|--|
| AND PLAN   | OF CORRECTION                            | IDENTIFICATION NUMBER          |         |          |  |                 | MPLETED    |  |
|  |  | 155059                         | B. WING |          |  | 08/03/2023      |            |  |
| NAME OF D  | ROVIDER OR SUPPLIER                      |                                |         | STREET A | ADDRESS, CITY, STATE, ZIP COD  | -               |            |  |
|  |  |                                |         |          | RANT ST  |                 |            |  |
| WATERS   | OF HUNTINGTON                            | I SKILLED NURSING FACILITY, T  | HE      | HUNTIN   | NGTON, IN 46750  |                 |            |  |
| (X4) ID  | SUMMARY S                                | STATEMENT OF DEFICIENCIE       |         | ID       | PROVIDER'S PLAN OF CORRECTION  |                 | (X5)       |  |
| PREFIX   | `  | CY MUST BE PRECEDED BY FULL    |         | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE (            | COMPLETION |  |
| TAG  |  | LSC IDENTIFYING INFORMATION    |         | TAG      | DEFICIENCY)  |                 | DATE       |  |
|  | iii. Patient lift and to                 |                                |         |          | Supervisor/designee inspected  | d all           |            |  |
|  | •  | ice affects 6 residents in the |         |          | corridors and exit doors for   |                 |            |  |
|  | area.                                    |                                |         |          | obstructions and found no other  | er              |            |  |
|  | Findings !1 1.                           |                                |         |          | negative findings.   |                 |            |  |
|  | Findings include:                        |                                |         |          | 3. MEASURES TO PREVE   | IN I            |            |  |
|  | Rased on an observe                      | ation during a tour of the     |         |          | REOCCURRENCE: a. On 8/15/2023 the                                      |                 |            |  |
|  |  | intenance Director on 08/03/23 |         |          | a. On 8/15/2023 the  Administrator inserviced the                      |                 |            |  |
|  | -  | area of resident rooms 79 and  |         |          | Maintenance Supervisor/desig   | inee            |            |  |
|  | _  | tive Equipment (PPE) carts     |         |          | and all other staff on the   | ,,,,,,          |            |  |
|  |  | e not equipped with wheels     |         |          | requirement that the corridor  |                 |            |  |
|  |  | be moved out of the halls      |         |          | means of egress are to remain  | ,               |            |  |
|  |  | y. The PPE carts were          |         |          | free of obstructions to meet se  | I .             |            |  |
|  | observed by rooms 79 and 87. Based on an |                                |         |          | standards.   |                 |            |  |
|  | interview at the time                    | e of observations, the         |         |          | b. Maintenance   |                 |            |  |
|  | Maintenance Direct                       | or stated the PPE carts were   |         |          | Supervisor/designee will inspe   | ect             |            |  |
|  | not equipped with w                      | wheels and would need to be    |         |          | all corridor means of egress   |                 |            |  |
|  | replaced with PPE of                     | earts with wheels.             |         |          | throughout the facility weekly t                                       | or              |            |  |
|  |  |                                |         |          | obstructions as a part of the  |                 |            |  |
|  | _  | riewed with the Administrator  |         |          | facility's Preventive Maintenar  |                 |            |  |
|  |  | e Director during the exit     |         |          | Program and document those   |                 |            |  |
|  | conference.                              |                                |         |          | inspection results as appropria  |                 |            |  |
|  | 2.1.10(1)                                |                                |         |          | If any issues are discovered, t  | -               |            |  |
|  | 3.1-19(b)                                |                                |         |          | will be addressed and resolve  |                 |            |  |
|  |  |                                |         |          | immediately. The Maintenanc  |                 |            |  |
|  |  |                                |         |          | 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  |                 |            |  |
|  |  |                                |         |          | CORRECTIVE ACTION:   |                 |            |  |
|  |  |                                |         |          | a. The inspection results w  | /ill            |            |  |
|  |  |                                |         |          | be presented by the Maintena   | I .             |            |  |
|  |  |                                |         |          | Supervisor/designee to the   |                 |            |  |
|  |  |                                |         |          | Administrator monthly and the  |                 |            |  |

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|                            | IT OF DEFICIENCIES<br>OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059  |     |                     |   | (X3) DATE SURVEY COMPLETED 08/03/2023 |                            |
|----------------------------|--|--|-----|---------------------|---|---------------------------------------|----------------------------|
|                            | PROVIDER OR SUPPLIER   | SKILLED NURSING FACILITY,  | THE | 1500 G              | ADDRESS, CITY, STATE, ZIP COD<br>GRANT ST<br>NGTON, IN 46750  |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)   | E                                     | (X5)<br>COMPLETION<br>DATE |
| K 0300<br>SS=C<br>Bldg. 01 | NFPA 101 Protection - Other Protection - Other List in the REMAR Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NI should be included Based on record rev observation, the fact documentation for to of battery operated rooms was complete existing life safety to if not required by th NFPA 72, 29.10 Ma Fire-warning equipatested in accordance | RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. | K 0 | 300                 | 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 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 8/4/2023  K300– It is the intent of the faci to ensure documentation for the preventative maintenance of battery operated smoke alarms resident rooms is complete to meet set standards.  CORRECTIVE ACTIONS TAKEN:  a) On 8/14/2023 the Maintenance Supervisor/design | e<br>y<br>s<br>sility<br>e            | 08/14/2023                 |

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of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,

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smoke alarms and documented on

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|               | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |  | (x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |               |   | (X3) DATE SURVEY  COMPLETED  08/03/2023 |                    |
|---------------|--|--|--|---------------|---|---|--------------------|
| NAME OF P     | ROVIDER OR SUPPLIER  |  | _  |               | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST  | -                                       |                    |
| WATERS        | OF HUNTINGTON  | I SKILLED NURSING FACILITY, T                            | HE   |               | NGTON, IN 46750   |   |                    |
| (X4) ID       |  | STATEMENT OF DEFICIENCIE                                 |  | ID            | PROVIDER'S PLAN OF CORRECTION   |   | (X5)               |
| PREFIX<br>TAG |  | CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION |  | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                                      | COMPLETION<br>DATE |
| 1110          |  | nance programs shall satisfy                             | 1  |               | the Battery-Operated Smoke  |   |                    |
|               |  | this Code and conform to the                             |  |               | Detector Maintenance Log to   | meet                                    |                    |
|               | equipment manufacturer's published instructions.   |  |  |               | set standards. The Administr  |   |                    |
|               | _  | ice could affect all residents,                          |  |               | verified the work on 8/14/2023  | 3.                                      |                    |
|               | staff, and visitors.   |  |  |               | 2) ALL OTHERS WITH  | -n.                                     |                    |
|               | Findings include:  |  |  |               | a) All residents and all sta  |   |                    |
|               | r manigs metade.   |  |  |               | and visitors have the potential   |   |                    |
|               | Based on records re  | view with the Maintenance                                |  |               | be affected but none were.  |   |                    |
|               |  | 8/03/23 at 11:15 a.m., no                                |  |               | 3) MEASURES TO PREVE  | NT                                      |                    |
|               | completed list for annual battery change of  |  |  |               | REOCCURRENCE:   |   |                    |
|               | resident room battery operated smoke alarms was  |  |  |               | a) On 8/14/2023 the   |   |                    |
|               | available for review. Based on interview at the  |  |  |               | Administrator inserviced the  |   |                    |
|               | time of review, the Maintenance Director stated  |  |  |               | Maintenance Supervisor/desi   | -                                       |                    |
|               |  | batteries were changed in                                |  |               | on the requirement that batter  | -                                       |                    |
|               | January but it was n   | ot recorded.   |  |               | operated smoke alarm batteri  |   |                    |
|               | This C. 1:   |  |  |               | must be changed and recorde   | d on                                    |                    |
|               | and MD at the exit   | viewed with the Administrator                            |  |               | the battery operated smoke  | oot                                     |                    |
|               | and wid at the exit of   | conference.  |  |               | detector log at the facility to m set standards.                                      | ieei                                    |                    |
|               | 3.1-19(b)  |  |  |               | b) Maintenance  |   |                    |
|               |  |  |  |               | Supervisor/designee will cond   | uct                                     |                    |
|               |  |  |  |               | testing on all battery-operated   |   |                    |
|               |  |  |  |               | smoke detectors per   |   |                    |
|               |  |  |  |               | manufacturer's guidelines   |   |                    |
|               |  |  |  |               | throughout the facility and   |   |                    |
|               |  |  |  |               | document the results on the   |   |                    |
|               |  |  |  |               | Battery-Operated Smoke Dete   |   |                    |
|               |  |  |  |               | Maintenance Log to be filed in<br>Life Safety Binder as a part of                     |   |                    |
|               |  |  |  |               | facility's monthly Preventive   | u IC                                    |                    |
|               |  |  |  |               | Maintenance Program. If any   | /                                       |                    |
|               |  |  |  |               | issues are discovered, they w   |   |                    |
|               |  |  |  |               | addressed and resolved  |   |                    |
|               |  |  |  |               | immediately. The Maintenand   | е                                       |                    |
|               |  |  |  |               | Supervisor/designee will revie  | w                                       |                    |
|               |  |  |  |               | with the Administrator the  |   |                    |
|               |  |  |  |               | inspection results.   |   |                    |
|               |  |  |  |               | c) The Administrator will   |   |                    |
|               |  |  | 1  |               | monitor adherence to the  |   | 1                  |

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| DEPARTMENT  | Γ OF HEALTH AND HU!  | MAN SERVICES                |      |         |   | FOI        | RM APPROVED     |
|-------------|----------------------|-----------------------------|------|---------|---|------------|-----------------|
| CENTERS FOI | R MEDICARE & MEDIC   |                             | _    |         |   | •          | IB NO. 0938-039 |
|             | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA  |      |         | ONSTRUCTION   | (X3) DATE  |                 |
| AND PLAN    | OF CORRECTION        | IDENTIFICATION NUMBER       |      | UILDING | <u>01</u>   | COMPL      |                 |
|             |                      | 155059                      | B. W | ING     |   | 08/03/2023 |                 |
|             | PROVIDER OR SUPPLIER |                             | TUE  | 1500 G  | ADDRESS, CITY, STATE, ZIP COD<br>SRANT ST<br>NGTON, IN 46750        |            |                 |
| WATERS      | OF HUNTINGTON        | I SKILLED NURSING FACILITY, | 100  | HUNTI   | NGTON, IN 46750   |            |                 |
| (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 | ιΤΕ        | COMPLETION      |
| TAG         | REGULATORY OR        | LSC IDENTIFYING INFORMATION |      | TAG     | DEFICIENCY)   |            | DATE            |
|             |                      |                             |      |         | Preventative Maintenance  |            |                 |
|             |                      |                             |      |         | schedule and validate the   |            |                 |
|             |                      |                             |      |         | Preventative Maintenance  |            |                 |
|             |                      |                             |      |         | documentation is in place.  |            |                 |
|             |                      |                             |      |         | 4) MONITORING   |            |                 |
|             |                      |                             |      |         | CORRECTIVE ACTION:  |            |                 |
|             |                      |                             |      |         | a) The inspection results v   | vill       |                 |
|             |                      |                             |      |         | be presented by the Maintena  | nce        |                 |
|             |                      |                             |      |         | Supervisor/designee to the  |            |                 |
|             |                      |                             |      |         | Administrator monthly and the                                       | ;          |                 |
|             |                      |                             |      |         | Administrator will present the                                      |            |                 |
|             |                      |                             |      |         | inspection results at the month                                     | nly        |                 |
|             |                      |                             |      |         | Quality Assurance/Performan   | ce         |                 |
|             |                      |                             |      |         | Improvement (QA/PI) meeting   | J.         |                 |
|             |                      |                             |      |         | Inspection results and system                                       |            |                 |
|             |                      |                             |      |         | components will be reviewed   | by         |                 |
|             |                      |                             |      |         | the QA/PI Committee with  |            |                 |
|             |                      |                             |      |         | subsequent plans of correctio                                       | n          |                 |
|             |                      |                             |      |         | developed and implemented a   | as         |                 |
|             |                      |                             |      |         | deemed necessary to ensure  |            |                 |
|             |                      |                             |      |         | compliance is maintained.   |            |                 |
|             |                      |                             |      |         | This plan of correction   |            |                 |
|             |                      |                             |      |         | constitutes our credible  |            |                 |
|             |                      |                             |      |         | allegation of compliance wit  | h          |                 |
|             |                      |                             |      |         | all regulatory requirements.  |            |                 |
|             |                      |                             |      |         | Our date of compliance is   |            |                 |
|             |                      |                             |      |         | 8/14/2023.  |            |                 |
| 14.00.45    |                      |                             |      |         |   |            |                 |
| K 0345      | NFPA 101             |                             |      |         |   |            |                 |
| SS=F        | Fire Alarm System    | n - Testing and             |      |         |   |            |                 |
| Bldg. 01    | Maintenance          |                             |      |         |   |            |                 |
|             | Fire Alarm System    | n - Testing and             |      |         |   |            |                 |
|             | Maintenance          |                             |      |         |   |            |                 |

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A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance

and testing are readily available.

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| DEPARTMENT OF HEALTH AND HUMAN SE  | CRVICES |
|------------------------------------|---------|
| CENTERS FOR MEDICARE & MEDICAID SE | RVICES  |

|                          | F OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |  | (X3) DATE SURVEY COMPLETED 08/03/2023   |                            |
|--------------------------|---|---|--|---------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIEF<br>OF HUNTINGTON  | R<br>N SKILLED NURSING FACILITY, T  | HE   | 1500 G              | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OF   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | TE  | (X5)<br>COMPLETION<br>DATE |
|                          | Based on record revision failed to ensure all alarm systems were maintained in accord. Fire Alarm Code. No Frequencies 14.4.5. devices to be insped deficient practice of the failed from the | view and interview, the facility smoke detectors for 1 of 1 fire inspected, tested, and redance with NFPA 72, National NFPA 72 Table Testing 15(7)(m) requires water flow eted and tested annually. This bould affect all occupants.  view with the Maintenance 18/03/23 at 11:30 a.m., the annual 1ted 04/19/22 indicated "1ty test on Fire System, aside 1tector above the nurses station and 1ted 04/19/22 indicated the ew, the Maintenance Director 1tector above the nurses 1ted 04/19/22 indicated 1tector above the nurses 1tector above the nurses 1ted 04/19/22 indicated 1tector above the nurses 1tector above the nurses 1tector above the nurses 1tector above | K 03   | 345                 | k345– It is the intent of the factor on ensure all smoke detectors fire alarm systems are inspect tested and maintained in accordance with NFPA 72, National Fire Alarm Code to meet standards.  1. CORRECTIVE ACTIONSTAKEN:  a. On 8/23/2023 a certified alarm contractor/designee reposite smoke detector above the nurse's station that was noted the fire alarm report dated 4/15 to meet set standards. The Administrator verified the repasive systems and all staff and visitors have the potential be affected but none were.  3. MEASURES TO PREVERECCURRENCE: a. On 8/15/2023 the Administrator inserviced the Maintenance Supervisor/designent that fire alars systems must be maintained in proper operating condition to reset standards. b. Maintenance Supervisor/designee will ensure fire alarm systems are maintain in proper operating condition apart of the facility's Preventive Maintenance Program and document those inspection reseas appropriate. If any issues | for for ed, seet S I fire aired on 9/22 ir on ED: f to ENT Innee airm on meet are need as a sults | 08/23/2023                 |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/25/2023 FORM APPROVED OMB NO. 0938-039

| CENTERS FOR   | C MEDICARE & MEDIC.  |                             |            |             |   |            | IB NO. 0938-039 |
|---|----------------------|-----------------------------|------------|-------------|---|------------|-----------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) |                      | (X2) N                      | MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY  |            |                 |
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER       | A. E       | BUILDING    | 01  | COMPLETED  |                 |
|   |                      | 155059                      |            | VING        |   | 08/03/2023 |                 |
|   |                      | 100000                      | Б. V       | ,110        |   | 00/03/     |                 |
| MARGORI   | DROLUDED OF GUIDNIES |                             |            | STREET      | ADDRESS, CITY, STATE, ZIP COD   |            |                 |
| NAME OF I   | PROVIDER OR SUPPLIER |                             |            | 1500 G      | GRANT ST  |            |                 |
| WATERS  | OF HUNTINGTON        | SKILLED NURSING FACILITY,   | THE        | HUNTI       | NGTON, IN 46750   |            |                 |
|   |                      | ,                           |            | 1           | - ,   |            | ·               |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE         | COMPLETION      |
| TAG   | REGULATORY OR        | LSC IDENTIFYING INFORMATION |            | TAG         | DEFICIENCY)   |            | DATE            |
|   |                      |                             |            |             | discovered, they will be addre  | ssed       |                 |
|   |                      |                             |            |             | and resolved immediately. Th  |            |                 |
|   |                      |                             |            |             | 1   |            |                 |
|   |                      |                             |            |             | Maintenance Supervisor/desig  |            |                 |
|   |                      |                             |            |             | will review with the Administra   | ιοΓ        |                 |
|   |                      |                             |            |             | the inspection results.   |            |                 |
|   |                      |                             |            |             | c. The Administrator will   |            |                 |
|   |                      |                             |            |             | monitor adherence to the  |            |                 |
|   |                      |                             |            |             | Preventative Maintenance  |            |                 |
|   |                      |                             |            |             | schedule and validate the   |            |                 |
|   |                      |                             |            |             | Preventative Maintenance  |            |                 |
|   |                      |                             |            |             | documentation is in place.  |            |                 |
|   |                      |                             |            |             | 1   |            |                 |
|   |                      |                             |            |             | 4. MONITORING   |            |                 |
|   |                      |                             |            |             | CORRECTIVE ACTION:  |            |                 |
|   |                      |                             |            |             | a. The inspection results w   |            |                 |
|   |                      |                             |            |             | be presented by the Maintena  | nce        |                 |
|   |                      |                             |            |             | Supervisor/designee to the  |            |                 |
|   |                      |                             |            |             | Administrator monthly and the   |            |                 |
|   |                      |                             |            |             | Administrator will present the  |            |                 |
|   |                      |                             |            |             | inspection results at the month   | alv        |                 |
|   |                      |                             |            |             |   | -          |                 |
|   |                      |                             |            |             | Quality Assurance/Performand  |            |                 |
|   |                      |                             |            |             | Improvement (QA/PI) meeting   |            |                 |
|   |                      |                             |            |             | Inspection results and system   |            |                 |
|   |                      |                             |            |             | components will be reviewed by  | эу         |                 |
|   |                      |                             |            |             | 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   | า          |                 |
|   |                      |                             |            |             | all regulatory requirements.  |            |                 |
|   |                      |                             |            |             | Our date of compliance is   |            |                 |
|   |                      |                             |            |             | 8/23/2023.  |            |                 |
|   |                      |                             |            |             |   |            | 1               |
| K 0353  | NFPA 101             |                             |            |             |   |            |                 |
| SS=F  |                      | - Maintenance and Testing   |            |             |   |            |                 |
| Bldg. 01  |                      | - Maintenance and Testing   |            |             |   |            |                 |
|   |                      |                             |            |             | Î.  |            | i .             |

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Automatic sprinkler and standpipe systems are inspected, tested, and maintained in

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Facility ID: 000020

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| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) M   | X2) MULTIPLE CONSTRUCTION |  |            | (X3) DATE SURVEY |  |
|-----------|--|---|----------|---------------------------|--|------------|------------------|--|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER                                     | A. BU    | ILDING                    |  |            | OMPLETED         |  |
|           |  | 155059  | B. WI    | NG                        |  | 08/03/2023 |                  |  |
|           |  |   | <u> </u> | STREET A                  | ADDRESS, CITY, STATE, ZIP COD  |            |                  |  |
| NAME OF F | PROVIDER OR SUPPLIER                                 | 8   |          |                           | RANT ST  |            |                  |  |
| WATERS    | OF HUNTINGTON  | SKILLED NURSING FACILITY, T                               | HE       |                           | NGTON, IN 46750  |            |                  |  |
| (X4) ID   | SUMMARY  | STATEMENT OF DEFICIENCIE                                  |          | ID                        | PROVIDER'S PLAN OF CORRECTION  |            | (X5)             |  |
| PREFIX    | · ·  | CY MUST BE PRECEDED BY FULL                               |          | PREFIX                    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE         | COMPLETION       |  |
| TAG       |  | R LSC IDENTIFYING INFORMATION                             |          | TAG                       | DEFICIENCY)  |            | DATE             |  |
|           |  | NFPA 25, Standard for the                                 |          |                           |  |            |                  |  |
|           |  | g, and Maintaining of                                     |          |                           |  |            |                  |  |
|           |  | Protection Systems.                                       |          |                           |  |            |                  |  |
|           | 1  | n design, maintenance,                                    |          |                           |  |            |                  |  |
|           | 1  | sting are maintained in a                                 |          |                           |  |            |                  |  |
|           |  | nd readily available.                                     |          |                           |  |            |                  |  |
|           | a) Date sprinkler                                    | system last checked                                       |          |                           |  |            |                  |  |
|           | b) Who provided system test                          |   |          |                           |  |            |                  |  |
|           | c) Water system                                      | supply source   |          |                           |  |            |                  |  |
|           | Provide in REMAR                                     | RKS information on  |          |                           |  |            |                  |  |
|           | coverage for any i                                   | non-required or partial                                   |          |                           |  |            |                  |  |
|           | automatic sprinkle                                   | er system.  |          |                           |  |            |                  |  |
|           | 9.7.5, 9.7.7, 9.7.8                                  |   |          |                           |  |            |                  |  |
|           |  | view and interview, the facility                          | K 0      | 353                       | K353 – It is the intent of the   |            | 08/18/2023       |  |
|           | _  | ritten documentation or other                             |          |                           | facility to ensure to provide wr                                       | itten      |                  |  |
|           | evidence the sprink                                  | ler system components had                                 |          |                           | documentation or other evider  | nce        |                  |  |
|           | _  | tested for 1 of 4 quarters. LSC                           |          |                           | the sprinkler system compone   | ents       |                  |  |
|           | _  | y device, equipment or system                             |          |                           | have been inspected and test   | ed         |                  |  |
|           |  | ance with this Code be                                    |          |                           | for all quarters to meet set   |            |                  |  |
|           |  | dance with applicable NFPA                                |          |                           | standards.   |            |                  |  |
|           |  | nkler systems shall be properly                           |          |                           | 4.00BBEOTIVE 4.0TIONS  |            |                  |  |
|           |  | rdance with NFPA 25, Standard Festing, and Maintenance of |          |                           | 1.CORRECTIVE ACTIONS TAKEN:  |            |                  |  |
|           | _  | Protection Systems. NFPA 25,                              |          |                           | 1.On 8/14/2023 the   |            |                  |  |
|           |  | ds shall be made for all                                  |          |                           | Administrator inserviced the   |            |                  |  |
|           |  | nd maintenance of the system                              |          |                           | Maintenance Supervisor/desig   | nnee       |                  |  |
|           |  | all be made available to the                              |          |                           | on the requirement that a licer  | -          |                  |  |
|           | 1 -  | risdiction upon request. 4.3.2                            |          |                           | sprinkler contractor must perfo  |            |                  |  |
|           |  | s shall indicate the procedure                            |          |                           | sprinkler system inspections   | 21111      |                  |  |
|           | _  | spection, test, or maintenance),                          |          |                           | quarterly and document the   |            |                  |  |
|           | ^ · · · ·  | at performed the work, the                                |          |                           | results to meet set standards.   |            |                  |  |
|           | _  | e. NFPA 25, 5.2.5 requires that                           |          |                           | 2.On September 7, 2022   |            |                  |  |
|           |  | vices shall be inspected                                  |          |                           | -  | u IC       |                  |  |
|           |  | hey are free of physical                                  |          |                           | facilities licensed sprinkler  | torly      |                  |  |
|           |  | , 5.3.3.1 requires the mechanical                         |          |                           | contractor performed the quar  | -          |                  |  |
|           | _  | vices including, but not limited                          |          |                           | sprinkler system inspection ar   |            |                  |  |
|           |  | gs, shall be tested quarterly.                            |          |                           | documented the results to me   |            |                  |  |
| I         | i io, water motor gon                                | igo, snan oe iesieu quarteriy.                            | 1        |                           | set standards. The Administra  | สเปเ       | Ī                |  |

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| DEPARTMENT OF HEALTH AND HUMAN S   | ERVICES |
|------------------------------------|---------|
| CENTERS FOR MEDICARE & MEDICAID SI | ERVICES |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |    |                     | (X3) DATE SURVEY  COMPLETED  08/03/2023  |  |                            |
|--|--|--|----|---------------------|--|--|----------------------------|
|  | ROVIDER OR SUPPLIER  | SKILLED NURSING FACILITY, T  | HE | 1500 G              | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750  | •  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | λΤΕ.   | (X5)<br>COMPLETION<br>DATE |
| PREFIX   | (EACH DEFICIEN REGULATORY OR 5.3.3.2 requires van switch-type waterfletested semiannually affect all residents, facility.  Findings include:  Based on review of inspection records v (MD) on 08/03/23 a quarterly sprinkler savailable for the thi September) of 2022 time of record revie acknowledged there documentation avail system had been insquarter of 2022. | e-type and pressure ow alarm devices shall be . This deficient practice could staff, and visitors in the  the quarterly sprinkler system with the Maintenance Director at 12:15 p.m., there was no system inspection report rd quarter (July, August, . During an interview at the w, the Maintenance Director was no written lable to show the sprinkler spected during the third |    | PREFIX              | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  | B.  ED:  aff I to  T  Ire n is  nce ate.  they d be ww | COMPLETION                 |
|  |  |  |    |                     | inspection results at the mont<br>Quality Assurance/Performan<br>Improvement (QA/PI) meeting<br>Inspection results and system<br>components will be reviewed | ce<br>J.   |                            |

| EPARTMENT OF HEALTH AND HUMAN SERVICES |                            |                            |    |  |  |  |  |  |
|--|----------------------------|----------------------------|----|--|--|--|--|--|
| CENTERS FOR MEDICARE & MEDICA          | AID SERVICES               |                            |    |  |  |  |  |  |
| STATEMENT OF DEFICIENCIES              | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X |  |  |  |  |  |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |   | (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       08/03/2023   |      |                     | ETED  |                     |                            |
|--|---|---|------|---------------------|---|---------------------|----------------------------|
|  | ROVIDER OR SUPPLIER   | I SKILLED NURSING FACILITY, T   | HE   | 1500 GF             | DDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>IGTON, IN 46750  |                     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | ΓE                  | (X5)<br>COMPLETION<br>DATE |
|  | NFPA 101 Portable Fire Extir Portable Fire Extir Portable fire exting installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to inspect 2 or in the laundry each Portable Fire Exting fire extinguishers sh manually or by mea system at a minimu 7.2.2 states periodic | nguishers nguishers nguishers nguishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility f 2 portable fire extinguishers month. NFPA 10, Standard for guishers, Section 7.2.1.2 states hall be inspected either ns of an electronic device / m of 30-day intervals. Section inspection or electronic extinguishers shall include a following items: | K 03 | TAG                 | CROSS-REFERENCED TO THE APPROPRIAT  | sility<br>re<br>ach |                            |
|  | (2) No obstruction t<br>(3) Pressure gauge to<br>operable range or pour (4) Fullness determined expelling-type of cartridge-operated expelling to Condition of tire nozzle for wheeled  | o access or visibility reading or indicator in the position uned by weighing or hefting for extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, and  |      |                     | documented the inspection to meet set standards. The Administrator verified the work 8/04/2023.  1.ALL OTHERS WITH POTENTIAL TO BE AFFECTE  1.All residents and all stat and visitors have the potential be affected but none were. | E <b>D</b> :        |                            |

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

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |  | Ĺ  | UILDING | onstruction  01     | (X3) DATE SI<br>COMPLE<br>08/03/2   | TED                              |                      |
|--|--|--|---------|---------------------|---|----------------------------------|----------------------|
|  | PROVIDER OR SUPPLIER   | I<br>R<br>N SKILLED NURSING FACILITY, T  | HE      | 1500 G              | ADDRESS, CITY, STATE, ZIP COD RANT ST NGTON, IN 46750   | l                                |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN REGULATORY OF using push to-test p Section 7.2.4.1 state inspections shall ke extinguishers insperequire corrective a where at least mont   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ressure indicators. es personnel making manual sep records of all fire cted, including those found to ction. Section 7.2.4.3 requires hly manual inspections are the manual inspection was     |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  2.MEASURES TO PREVEN' REOCCURRENCE:  1.On 8/15/2023 the Administrator inserviced the Maintenance Supervisor/desig that portable fire extinguishers must be inspected monthly an  | T<br>gnee                        | (X5) COMPLETION DATE |
|  | performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a talextinguisher, on an maintained on file, Section 7.2.4.5 requarements are that at inspections have be practice could affect Findings include:  Based on observation with the Maintenan at 02:20 p.m., the market inspection in the maintenan at 02:20 p.m., the market inspection in the maintenant | nitials of the person section shall be recorded. sires where manual inspections rds for manual inspections ag or label attached to the fire inspection checklist or by an electronic method. sires records shall be kept to least the last 12 monthly en performed. This deficient |         |                     | documented to meet set standards.  2.Maintenance Supervisor/designee will ensu portable fire extinguishers are inspected monthly and documented as a part of the facility's monthly Preventive Maintenance Program and document those inspection resas appropriate. If any issues discovered, they will be addresand resolved immediately. The Maintenance Supervisor/designily review with the Administrative inspection results.  3.The Administrator will monitor adherence to the | re<br>sults<br>are<br>ssed<br>ae |                      |
|  | documentation of r<br>2023. Based on inte<br>observation, the MI<br>extinguisher located<br>in laundry were mis<br>visual inspection.  | monthly inspections for July erview at the time of D confirmed the fire d by the two fire extinguishers using the July 2023 monthly viewed with the Administrator  |         |                     | Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  3.MONITORING CORRECT ACTION:  1.The inspection results to be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system  | will<br>nce<br>nly<br>ce         |                      |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION 01      | (X3) DATE SURVEY COMPLETED 08/03/2023   |                       |
|--|--|---|---------------------|---|-----------------------|
|  | ROVIDER OR SUPPLIER  | I SKILLED NURSING FACILITY, T   | 1500 G              | ADDRESS, CITY, STATE, ZIP COD<br>IRANT ST<br>NGTON, IN 46750  |                       |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | DATE                  |
|  |  |   |                     | 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 8/4/2023. | n<br>s                |
| K 0712<br>SS=F<br>Bldg. 01   | alarm signal and seconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00 announcement madible alarms. 19.7.1.4 through 1 Based on record revalled to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (rengineers, and admissignals and emerger varied conditions. Tall staff and residen | 9.7.1.7 riew and interview, the facility e drills on each shift for 1 of 4 1.6 states drills shall be on each shift to familiarize curses, interns, maintenance curstrative staff) with the ney action required under this deficient practice affects | K 0712              | K712 – It is the intent of the facility to ensure to conduct fir drills on each shift for all 4 quarters and to ensure fire dril included the verification of transmission of the fire alarm signal to the monitoring statior fire drills conducted between 9 pm and 6:00 am for all quarter meet set standards.        | n in<br>0:00<br>es to |
|  | Findings include:  |   |                     | 1. CORRECTIVE ACTION TAKEN:   | S                     |

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| CENTERS FOR MEDICARE & MEDICAID SERVICES |                        |                                       |        |                  |   | _         | B NO. 0938-039 |
|--|------------------------|---------------------------------------|--------|------------------|---|-----------|----------------|
| STATEMEN                                 | T OF DEFICIENCIES      | X1) PROVIDER/SUPPLIER/CLIA            | (X2) N | IULTIPLE CO      | ONSTRUCTION   | (X3) DATE | SURVEY         |
| AND PLAN                                 | OF CORRECTION          | IDENTIFICATION NUMBER                 | A. B   | UILDING          | 01  | COMPL     | ETED           |
|  |                        | 155059                                | B. W   | 'ING             |   | 08/03     | /2023          |
| WATERS                                   | Г                      | SKILLED NURSING FACILITY,             | THE    | 1500 G<br>HUNTII | ADDRESS, CITY, STATE, ZIP COD<br>FRANT ST<br>NGTON, IN 46750                          |           | (VE)           |
| (X4) ID                                  |                        | STATEMENT OF DEFICIENCIE              |        | ID               | PROVIDER'S PLAN OF CORRECTION   |           | (X5)           |
| PREFIX                                   | `                      | CY MUST BE PRECEDED BY FULL           |        | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE       | COMPLETION     |
| TAG                                      |                        | LISC IDENTIFYING INFORMATION          |        | TAG              |   |           | DATE           |
|  |                        | review with the Maintenance           |        |                  | a. On 8/15/2023 the   |           |                |
|  |                        | 3 at 10:15 a.m., the first shift fire |        |                  | Administrator inserviced the  |           |                |
|  |                        | narter of 2022 was missing            |        |                  | Maintenance Supervisor/desi   | -         |                |
|  |                        | completed fire drill. Based on        |        |                  | on the requirement that fire d  |           |                |
|  |                        | e of record review, the               |        |                  | must be conducted at unexpe   |           |                |
|  |                        | ors stated the drills were            |        |                  | times under varying condition   |           |                |
|  | completed but could    | d not find the documentation.         |        |                  | least quarterly on each shift a   | ind       |                |
|  |                        |                                       |        |                  | documented to meet set  |           |                |
|  |                        | viewed with the Administrator         |        |                  | standards.  |           |                |
|  | and MD at the exit     | conference.                           |        |                  | b. On   |           |                |
|  |                        |                                       |        |                  | 8/23/2023,8/24/2023,8/25/202  | 23        |                |
|  | 3.1-19(b)              |                                       |        |                  | the Maintenance   |           |                |
|  |                        |                                       |        |                  | Supervisor/designee conduct   |           |                |
|  |                        | review and interview, the             |        |                  | fire drill for each of the three s  | shifts    |                |
|  |                        | sure 3 of 12 fire drills included     |        |                  | including the transmission of   |           |                |
|  | the verification of to | ransmission of the fire alarm         |        |                  | signal and documented the re  | esults    |                |
|  | signal to the monito   | oring station in fire drills          |        |                  | in the facilities/ Life Safety Bir  | nder      |                |
|  | conducted between      | 9:00 p.m. and 6:00 a.m. for the       |        |                  | to meet set standards. The  |           |                |
|  | last 4 quarters. LSC   | C 19.7.1.4 requires fire drills in    |        |                  | Administrator verified the drill  | s on      |                |
|  | health care occupan    | cies shall include the                |        |                  | 8/25/2023.  |           |                |
|  | transmission of a fir  | re alarm signal and simulation        |        |                  | 2. ALL OTHERS WITH  |           |                |
|  | of emergency fire c    | onditions. This deficient             |        |                  | POTENTIAL TO BE AFFECT  | ED:       |                |
|  | practice affects all r | residents in the facility as well     |        |                  | a. All residents and all sta  | ff        |                |
|  | as staff and visitors  |                                       |        |                  | and visitors have the potentia  | l to      |                |
|  |                        |                                       |        |                  | be affected but none were.  |           |                |
|  | Findings include:      |                                       |        |                  | 3. MEASURES TO PREV   | ENT       |                |
|  |                        |                                       |        |                  | REOCCURRENCE:   |           |                |
|  | Based on records re    | view with the Maintenance             |        |                  | a. Maintenance  |           |                |
|  | Director on 08/03/2    | 3 at 10:15 a.m., the fire drill       |        |                  | Supervisor/designee will ensu   | ıre       |                |
|  | forms for third shift  | drills indicated transmission         |        |                  | fire drills are conducted at  |           |                |
|  | of signal was not te   | sted on 06/08/23, 05/09/23, and       |        |                  | unexpected times under vary   | ing       |                |
|  | 03/03/23. On 05/08     | /23 the silent drill was done at      |        |                  | conditions at least quarterly o   | n         |                |
|  | 07:00 p.m. which is    | not in the correct time frame.        |        |                  | each shift including the  |           |                |
|  | Based on interview     | at the time of record review,         |        |                  | transmission of signal on all s   | hifts     |                |
|  | the Maintenance Di     | rector stated he did not              |        |                  | and documented on the Fire I  | Drill     |                |
|  | transmit the single t  | he next day and was unaware           |        |                  | Report and that documentation   | n be      |                |
|  | the transmission of    | signal had to be tested for           |        |                  | retained in the facility's Life S   |           |                |
|  | drills on third shift. |                                       |        |                  | Binder as a part of the facility  | -         |                |

These findings were reviewed with the

Preventive Maintenance Program

and document those inspection

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTERS FOI | R MEDICARE & MEDIC  | CAID SERVICES                   |        |            |  | OM               | IB NO. 0938-039 |
|-------------|---------------------|---------------------------------|--------|------------|--|------------------|-----------------|
| STATEMEN    | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA      | (X2) M | ULTIPLE CO | ONSTRUCTION  | (X3) DATE SURVEY |                 |
| AND PLAN    | OF CORRECTION       | IDENTIFICATION NUMBER           | A. BU  | JILDING    | 01   | COMPLETED        |                 |
|             |                     | 155059                          | B. W   | ING        |  | 08/03/2023       |                 |
|             | PROVIDER OR SUPPLIE | R<br>N SKILLED NURSING FACILITY | , THE  | 1500 G     | ADDRESS, CITY, STATE, ZIP COD<br>SRANT ST<br>NGTON, IN 46750         | •                |                 |
| (X4) ID     | SUMMARY             | STATEMENT OF DEFICIENCIE        |        | ID         | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)            |
| PREFIX      | (EACH DEFICIE)      | NCY MUST BE PRECEDED BY FULL    |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR | IATE             | COMPLETION      |
| TAG         | REGULATORY O        | R LSC IDENTIFYING INFORMATION   |        | TAG        | DEFICIENCY)  |                  | DATE            |
|             | Administrator and   | Maintenance Director at the     |        |            | results as appropriate. If an  | у                |                 |
|             | exit conference.    |                                 |        |            | issues are discovered, they was                                      | vill be          |                 |
|             |                     |                                 |        |            | addressed and resolved   |                  |                 |
|             | 3.1-19(b)           |                                 |        |            | immediately. The Maintenar   | ice              |                 |
|             |                     |                                 |        |            | Supervisor/designee will revi  |                  |                 |
|             |                     |                                 |        |            | with the Administrator the   |                  |                 |
|             |                     |                                 |        |            | inspection results.  |                  |                 |
|             |                     |                                 |        |            | b. The Administrator will  |                  |                 |
|             |                     |                                 |        |            | monitor adherence to the   |                  |                 |
|             |                     |                                 |        |            | Preventative Maintenance   |                  |                 |
|             |                     |                                 |        |            | schedule and validate the  |                  |                 |
|             |                     |                                 |        |            | Preventative Maintenance   |                  |                 |
|             |                     |                                 |        |            | documentation is in place.   |                  |                 |
|             |                     |                                 |        |            | 4. MONITORING  |                  |                 |
|             |                     |                                 |        |            | CORRECTIVE ACTION:   |                  |                 |
|             |                     |                                 |        |            |  | vazill           |                 |
|             |                     |                                 |        |            | 1  |                  |                 |
|             |                     |                                 |        |            | be presented by the Mainten  | ance             |                 |
|             |                     |                                 |        |            | Supervisor/designee to the   | _                |                 |
|             |                     |                                 |        |            | Administrator monthly and th   |                  |                 |
|             |                     |                                 |        |            | Administrator will present the                                       |                  |                 |
|             |                     |                                 |        |            | inspection results at the mon  | -                |                 |
|             |                     |                                 |        |            | Quality Assurance/Performa   |                  |                 |
|             |                     |                                 |        |            | Improvement (QA/PI) meetin   | -                |                 |
|             |                     |                                 |        |            | Inspection results and syster  |                  |                 |
|             |                     |                                 |        |            | components will be reviewed  | ру               |                 |
|             |                     |                                 |        |            | the QA/PI Committee with   |                  |                 |
|             |                     |                                 |        |            | subsequent plans of correction                                       |                  |                 |
|             |                     |                                 |        |            | developed and implemented  |                  |                 |
|             |                     |                                 |        |            | deemed necessary to ensure   | )                |                 |
|             |                     |                                 |        |            | compliance is maintained.  |                  |                 |
|             |                     |                                 |        |            | This plan of correction  |                  |                 |
|             |                     |                                 |        |            | constitutes our credible   |                  |                 |
|             |                     |                                 |        |            | allegation of compliance wi  |                  |                 |
|             |                     |                                 |        |            | all regulatory requirements  |                  |                 |
|             |                     |                                 |        |            | Our date of compliance is  |                  |                 |
|             |                     |                                 |        |            | 8/25/2023.   |                  |                 |
|             |                     |                                 |        |            |  |                  |                 |
| K 0761      |                     |                                 |        |            |  |                  |                 |

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SS=F Bldg. 01

Event ID:

 $ONW021 \quad \ \ \text{Facility ID:} \quad \ 000020$ 

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| CENTERS FOR MEDICARE & MEDICAID SERVICES |                                    |                                  |        |                            |  | OM    | B NO. 0938-039   |  |
|--|------------------------------------|----------------------------------|--------|----------------------------|--|-------|------------------|--|
| STATEMEN                                 | T OF DEFICIENCIES                  | X1) PROVIDER/SUPPLIER/CLIA       | (X2) M | (X2) MULTIPLE CONSTRUCTION |  |       | (X3) DATE SURVEY |  |
| AND PLAN                                 | OF CORRECTION                      | IDENTIFICATION NUMBER            | A. BU  | A. BUILDING 01             |  |       | COMPLETED        |  |
|  |                                    | 155059                           | B. W   | ING                        |  | 08/03 | /2023            |  |
|  |                                    |                                  |        | CTDEET                     | ADDRESS, CITY, STATE, ZIP COD  |       |                  |  |
| NAME OF F                                | PROVIDER OR SUPPLIEF               | 8                                |        |                            | FRANT ST   |       |                  |  |
| WATERS                                   | OF HUNTINGTON                      | SKILLED NURSING FACILITY,        | THE    |                            | NGTON, IN 46750  |       |                  |  |
| (X4) ID                                  | D 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<br>CROSS-REFERENCED TO THE APPROPRIA | TE    | COMPLETION       |  |
| TAG                                      | REGULATORY OF                      | LSC IDENTIFYING INFORMATION      |        | TAG                        | DEFICIENCY)  | 16    | DATE             |  |
|  | Based on observation               | on, records review, and          | K 0    | 761                        | K761 – It is the intent of the   |       | 08/04/2023       |  |
|  | interview, the facili              | ty failed to ensure annual       |        |                            | facility to ensure annual inspe  | ction |                  |  |
|  | inspection and testi               | ng of fire door assemblies       |        |                            | and testing of all fire door   |       |                  |  |
|  | _                                  | accordance of LSC 19.1.1.4.1.1   |        |                            | assemblies are completed in  |       |                  |  |
|  | communicating ope                  | enings in dividing fire barriers |        |                            | accordance of LSC 19.1.1.4.1   | .1    |                  |  |
|  |                                    | 1.1 shall be permitted only in   |        |                            | communicating openings in  |       |                  |  |
|  |                                    | be protected by approved         |        |                            | dividing fire barriers required by                                     | οV    |                  |  |
|  |                                    | or assemblies. (See also Section |        |                            | 19.1.1.4.1 shall be permitted of                                       | •     |                  |  |
|  | _                                  | penings required to have a fire  |        |                            | in corridors and shall be prote  | -     |                  |  |
|  | · ·                                | Table 8.3.4.2 shall be           |        |                            | by approved self-closing fire d  |       |                  |  |
|  |                                    | ved, listed, labeled fire door   |        |                            | assemblies to meet set   |       |                  |  |
|  |                                    | window assemblies and their      |        | standards.                 |  |       |                  |  |
|  |                                    | ware, including all frames,      |        | 1. CORRECTIVE ACT          |  | S     |                  |  |
|  | closing devices, and               | <u>~</u>                         |        |                            | TAKEN:   |       |                  |  |
|  | -                                  | e requirements of NFPA 80,       |        |                            | a. On 8/4/2023 the   |       |                  |  |
|  |                                    | oors and Other Opening           |        |                            | Maintenance Supervisor/desig   | inee  |                  |  |
|  |                                    | as otherwise specified in this   |        |                            | conducted the annual inspecti  |       |                  |  |
|  | -                                  | .1 states fire door assemblies   |        |                            | for the fire door assemblies ar  |       |                  |  |
|  |                                    | nd tested not less than          |        |                            | documented those inspection  |       |                  |  |
|  | _                                  | tten record of the inspection    |        |                            | results on the Annual Door   |       |                  |  |
|  | -                                  | kept for inspection by the       |        |                            | Inspections log to meet set  |       |                  |  |
|  | -                                  | .4.1 states fire door assemblies |        |                            | standards. The Administrator   |       |                  |  |
|  | · ·                                | spected from both sides to       |        |                            | verified the inspections and   |       |                  |  |
|  |                                    | ondition of door assembly.       |        |                            | documentation on 8/4/2023.   |       |                  |  |
|  |                                    | tates as a minimum, the          |        |                            | 2. ALL OTHERS WITH   |       |                  |  |
|  | following items sha                |                                  |        |                            | POTENTIAL TO BE AFFECTE  | -D·   |                  |  |
|  | _                                  | or breaks exist in surfaces of   |        |                            | a. All residents and all state   |       |                  |  |
|  | either the door or fr              |                                  |        |                            | and visitors have the potential  |       |                  |  |
|  |                                    | light frames, and glazing beads  |        |                            | be affected but none were.   | io    |                  |  |
|  |                                    | ely fastened in place, if so     |        |                            | 3. MEASURES TO PREVE   | ENIT  |                  |  |
|  | equipped.                          | ery rustement in place, it so    |        |                            | REOCCURRENCE:  | -141  |                  |  |
|  |                                    | , hinges, hardware, and          |        |                            | 0 0//0/0000  |       |                  |  |
|  |                                    | eshold are secured, aligned,     |        |                            |  | rtv   |                  |  |
|  |                                    | er with no visible signs of      |        |                            | Administrator/corporate Prope Manager inserviced the                   | пту   |                  |  |
|  | damage.                            | or with no visible signs of      |        |                            | _  | ınoo  |                  |  |
|  |                                    | esing or broken                  |        |                            | Maintenance Supervisor/desig   | •     |                  |  |
|  | (4) No parts are mis               | _                                |        |                            | on the requirement that annua  |       |                  |  |
|  |                                    | do not exceed clearances         |        |                            | testing & inspections of fire do                                       |       |                  |  |
|  | listed in 4.8.4 and 6              | .5.1./.                          |        |                            | assemblies must be conducte  | a to  |                  |  |

(6) The self-closing device is operational; that is,

the active door completely closes when operated

ensure proper operation and

documented on the Annual Door

| DEPARTMENT O  | F HEALTH AND | HUMAN SERVICES   |  |
|---------------|--------------|------------------|--|
| CENTERS FOR M | EDICARE & ME | EDICAID SERVICES |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155059   | A. BU | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED 08/03/2023              |                            |
|--------------------------|--|---|-------|--|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIER  | N SKILLED NURSING FACILITY, T   | HE    | 1500 GI  | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |       | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE   | (X5)<br>COMPLETION<br>DATE |
|                          | from the full open p (7) If a coordinator closes before the ac (8) Latching hardwedoor when it is in th (9) Auxiliary hardwedoor prohibit operation as frame. (10) No field modificate have been performed (11) Gasketing and inspected to verify the deficient pract  Findings include:  Based on record revelopment of the properties of the p | position.  is installed, the inactive leaf stive leaf.  are operates and secures the ne closed position.  vare items that interfere or are not installed on the door or assembly ed that void the label.  edge seals, where required, are their presence and integrity.  ice could affect all residents.  view with the Maintenance (8/03/23 documentation of an or the fire door assemblies was to but was dated 05/13/22.  at the time of records review the MD stated he was unaware door inspection had expired.  viewed with the Administrator |       |  | Inspections log to meet set standards. b. Maintenance Supervisor/designee will cond the annual inspection of fire dassemblies to ensure proper operation and document the inspection results on the Annu Door Inspection log as a part the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/designel 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 where the 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 components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure | oor  all of  sults are ssed ae gnee ttor  will nce |                            |

PRINTED: 08/25/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 08/03/2023   |   |                     |  | ETED |                            |
|--|--|---|---|---------------------|--|------|----------------------------|
|  | PROVIDER OR SUPPLIER   | N SKILLED NURSING FACILITY,   | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HUNTINGTON, IN 46750 |                     |  |      |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)  | TE   | (X5)<br>COMPLETION<br>DATE |
|  |  |   |   |                     | compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/04/2023. | 1    |                            |
| K 0918<br>SS=F<br>Bldg. 01   | Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availal | s - Essential Electric Syste s - Essential Electric Ince and Testing other alternate power inted equipment is capable be within 10 seconds. If the in is not met during the process shall be provided to this capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised intervals, and exercised intervals and conditions include atted cold start and the inspected by competent in the inspected in the store of all EES inducted by competent in the process of the store of the |   |                     |  |      |                            |

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ONW021 Facility ID: 000020

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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 B. WING 08/03/2023 155059 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1500 GRANT ST WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE **HUNTINGTON. IN 46750** (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 and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4. 6.5.4. 6.6.4 (NFPA 99), NFPA 110. NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the K 0918 **K918**– It is the intent of the facility 08/21/2023 facility failed to maintain 1 of 1 Emergency Power to ensure to maintain emergency Standby System in accordance with NFPA 110, power standby system in Standard for Emergency and Standby Power accordance with NFPA 110, Systems, Section 8.4.9, as required by NFPA 99 standard for emergency and Health Care Facilities Code, Section 6.4.1.1.6.1. standby power systems, Section NFPA 110 Section 8.4.9 states that all Level 1 8.4.9, as required by NFPA 99 Emergency Power Systems shall be tested at least healthcare facilities code, section once within every three years. Where the 6.4.1.1.6.1 and to ensure an assigned class is greater than 4 hours, it shall be annual fuel quality test is permitted to terminate the test after 4 hours. performed for facility diesel NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and powered generators to meet set Type 2 essential electrical system power sources standards. shall be classified at Type 10, Class X, Level 1 CORRECTIVE ACTIONS 1. generator sets. This deficient practice could TAKEN: affect all building occupants. On 8/21/23 the Maintenance Supervisor/designee Findings include: will conduct the four hour run test for the emergency generator and During records review with the Maintenance document the results to meet set Director on 08/03/20 at 11:50 a.m., documentation standards. The Administrator of a four hour run test for the emergency verified the work on 8/22/2023. generator conducted within the last 36 months On 2/17/23 the Facilities was not provided for review. Based on interview Certified Generator Contractor at the time of records review, the Maintenance performed the annual fuel quality Director stated a four hour continuous run under test for the diesel generator and load was not conducted in the past 36 months. documented the results to meet The set standards. This finding was reviewed with the Administrator Administrator verified the work on and Maintenance Director at the exit conference.

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3.1-19(b)

2. Based on record review and interview, the

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**ALL OTHERS WITH** 

POTENTIAL TO BE AFFECTED: All residents and all staff

and visitors have the potential to

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |   | A. B  | A. BUILDING <u>01</u> |                     | COMPL   | 3) DATE SURVEY COMPLETED 08/03/2023                                      |                            |
|--|---|---|-----------------------|---------------------|---|--|----------------------------|
|  | PROVIDER OR SUPPLIER  | N SKILLED NURSING FACILITY,   | THE                   | 1500 G              | ADDRESS, CITY, STATE, ZIP COD<br>RANT ST<br>NGTON, IN 46750   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   |                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | λΤΕ  | (X5)<br>COMPLETION<br>DATE |
|  | was performed for generators. NFPA 2012 Edition Section (Essential Electrical be inspected and test section 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect Findings include:  Based on records red Director on 08/03/2 documentation of a the diesel generator Based on interview the Maintenance Defind the documentatest at the time of the This finding was red. | eview with the Maintenance<br>23 at 01:00 p.m., no<br>n annual fuel quality test for<br>was available for review.<br>at the time of records review,<br>irector stated he was unable to<br>tion of the annual fuel quality |                       |                     | be affected but none were.  3. MEASURES TO PREVIREOCCURRENCE: a. On 8/15/2023 the Administrator inserviced the Maintenance Supervisor/design on the requirement that a four run test on the emergency generator must be conducted once every three years and a quality test must be performed annually and documented to rest standards.  b. The Maintenance Supervisor/designee will ensure four hour run test on the emergency generator is conditionate once every three years and an annual fuel quality test is performed and documented a part of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/design will review with the Administrative 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 were presented by the Maintenance and the maintenance documentation is in place. | gnee hour  fuel d meet  ire a  ucted n s a e sults are ssed ne gnee itor |                            |

Supervisor/designee to the

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155059 |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |  |                     | (X3) DATE SURVEY COMPLETED 08/03/2023   |                                  |                            |  |
|--|---|--|--|---------------------|---|----------------------------------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGTON SKILLED NURSING FACILITY, TH                           |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HE HUNTINGTON, IN 46750 |                     |   |                                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | ATE                              | (X5)<br>COMPLETION<br>DATE |  |
| K 0920<br>SS=E<br>Bldg. 01   | Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vir non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard | ent - Power Cords and ent - Power Cords and ent - Power Cords and ent in the care vicinity are only ents of movable end electrical equipment es that have been elified personnel and meet elified personnel and me |  |                     | Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan 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 8/21/2023. | hly<br>ce<br>g.<br>by<br>n<br>as |                            |  |

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ONW021 Facility ID: 000020

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| STATEMENT OF DEFICIENCIES    |                                  | X1) PROVIDER/SUPPLIER/CLIA         | (X2) MULTIPLE CONSTI  |        | ONSTRUCTION  | (X3) DATE SURVEY                  |            |
|------------------------------|----------------------------------|------------------------------------|-----------------------|--------|--|-----------------------------------|------------|
| AND PLAN OF CORRECTION       |                                  | IDENTIFICATION NUMBER              | a. Building <u>01</u> |        | 01   | COMPLETED                         |            |
| 155059                       |                                  | 155059                             | B. WING               |        |  | 08/03/2023                        |            |
|                              |                                  |                                    |                       | CTREET | ADDRESS CITY STATE ZID SOD   |                                   |            |
| NAME OF PROVIDER OR SUPPLIER |                                  |                                    |                       |        | ADDRESS, CITY, STATE, ZIP COD  |                                   |            |
|                              |                                  |                                    | –                     |        | SRANT ST   |                                   |            |
| WATERS                       | S OF HUNTINGTON                  | N SKILLED NURSING FACILITY, T      | HE                    | HUNII  | NGTON, IN 46750  |                                   |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIATE |                                   | COMPLETION |
| TAG                          | REGULATORY OF                    | R LSC IDENTIFYING INFORMATION      |                       | TAG    | DEFICIENCY)  |                                   | DATE       |
|                              | cords are not used               | d as a substitute for fixed        |                       |        |  |                                   |            |
|                              | wiring of a structu              | re. Extension cords used           |                       |        |  |                                   |            |
|                              | _                                | moved immediately upon             |                       |        |  |                                   |            |
|                              |                                  | purpose for which it was           |                       |        |  |                                   |            |
|                              | •                                | ts the conditions of 10.2.4.       |                       |        |  |                                   |            |
|                              |                                  | 9), 10.2.4 (NFPA 99), 400-8        |                       |        |  |                                   |            |
|                              | ,                                | (D) (NFPA 70), TIA 12-5            |                       |        |  |                                   |            |
|                              |                                  | on and interview, the facility     | K 09                  | 920    | K920- It is the intent of the fac  | of the facility $08/07/2023$      |            |
|                              |                                  | of 2 power cord daisy chains       |                       |        | to ensure power cord daisy chains  |                                   |            |
|                              |                                  | d as a substitute for fixed        |                       |        | are not used as a substitute fo  |                                   |            |
|                              | wiring. NFPA-70/2                | 011, 400.8 state unless            |                       |        | fixed wiring and to ensure flex  |                                   |            |
|                              | _                                | ed in 400.7 flexible cords and     |                       |        | cords are installed properly ar  |                                   |            |
|                              |                                  | used for (1) as a substitute for   |                       |        | used in a safe manner to mee   |                                   |            |
|                              |                                  | e 400.8 (1) prohibits daisy        |                       |        | standards.   |                                   |            |
|                              | _                                | first extension cord (or power     |                       |        | 1. CORRECTIVE ACTION   | S                                 |            |
|                              |                                  | as a substitute for the fixed      |                       |        | TAKEN:   |                                   |            |
|                              |                                  | e. This deficient practice could   |                       |        | a. On 8/7/2023 the   |                                   |            |
|                              | affect up to 10 resid            | -                                  |                       |        | Maintenance Supervisor/design  | nee                               |            |
|                              | compartment.                     |                                    |                       |        | removed the two power strips   | -                                 |            |
|                              | ·                                |                                    |                       |        | the Office Supply closest to m   |                                   |            |
|                              | Findings include:                |                                    |                       |        | set standards. The Administra  | •                                 |            |
|                              |                                  |                                    |                       |        | verified the removal of the cor  | ds on                             |            |
|                              | Based on observa                 | ations during a tour of the        |                       |        | 8/7/2023.  |                                   |            |
|                              |                                  | intenance Director (MD) on         |                       |        | 2. ALL OTHERS WITH   |                                   |            |
|                              | _                                | .m. in the Office Supply closet, a |                       |        | POTENTAL TO BE AFFECTE   | D:                                |            |
|                              | _                                | gged into and supplied power       |                       |        | a. All residents and all state   |                                   |            |
|                              |                                  | trip. Based on interview at the    |                       |        | and visitors have the potential  | to                                |            |
|                              |                                  | , the Maintenance Director         |                       |        | be affected but none were. O   |                                   |            |
|                              |                                  | was daisy chained to another       |                       |        | 8/7/2023 the Maintenance   |                                   |            |
|                              | power strip.                     |                                    |                       |        | Supervisor/designee inspecte   | d all                             |            |
|                              |                                  |                                    |                       |        | rooms throughout the facility for  |                                   |            |
|                              | 2. Based on observa              | ation and interview, the facility  |                       |        | power strips and found no oth  |                                   |            |
|                              |                                  | f 1 flexible cords were installed  |                       |        | negative findings.   |                                   |            |
|                              | properly and used in             | n a safe manor. NFPA 99,           |                       |        | 3. MEASURES TO PREVE   | ENT                               |            |
|                              | Section 10.2.4.2 sta             | tes adapters and extension         |                       |        | REOCCURRENCE:  |                                   |            |
|                              | cords meeting the re             | equirements of 10.2.4.2.1          |                       |        | a. On 8/14/2023 the  |                                   |            |
|                              | through 10.2.4.2.3 s             | shall be permitted. Section        |                       |        | Administrator inserviced the   |                                   |            |
|                              | 10.2.4.2.3 states the            | e cabling shall comply with        |                       |        | Maintenance Supervisor/desig   | gnee                              |            |
|                              | 10.2.3. Section 10.2             | 2.3.5.1 states cord strain relief  |                       |        | and all other staff on the   |                                   |            |
|                              | shall be provided at             | the attachment of the power        |                       |        | requirement that power strips  | requirement that power strips are |            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) M                           | (X2) MULTIPLE CONSTRUCTION |        |   | (X3) DATE SURVEY |            |
|--|---|----------------------------------|----------------------------|--------|---|------------------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER         |   | A. BUILDING <u>01</u>            |                            |        | COMPLETED   |                  |            |
| 155059   |   | B. W                             | B. WING                    |        |   | /2023            |            |
|  |   |                                  |                            | STREET | ADDRESS, CITY, STATE, ZIP COD   |                  |            |
| NAME OF  | PROVIDER OR SUPPLIE   | R                                |                            |        | BRANT ST  |                  |            |
| WATER!   | S OF HUNTINGTO  | N SKILLED NURSING FACILITY,      | THF                        |        | NGTON, IN 46750   |                  |            |
|  | 1   |                                  | ··· <del>-</del>           |        | 1   |                  | T          |
| (X4) ID  |   | STATEMENT OF DEFICIENCIE         |                            | ID     | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)       |
| PREFIX   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION                     |                                  |                            | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE              | COMPLETION |
| TAG  |   |                                  |                            | TAG    |   | •                | DATE       |
|  |   | ce so that mechanical stress,    |                            |        | not to be used as a substitute  |                  |            |
|  | either pull, twist, or bend, is not transmitted to  |                                  |                            |        | fixed wiring to meet set stand  | ards.            |            |
|  | internal connections. This deficient practice could affect up to 10 residents in one smoke compartment. |                                  |                            |        | b. Maintenance  | act              |            |
|  |   |                                  |                            |        | Supervisor/designee will inspending all rooms throughout the facility                 |                  |            |
|  |   |                                  |                            |        | monthly and remove any non  | ιy               |            |
|  | Findings include:   | dings include                    |                            |        | approved power strips found a   | 26.2             |            |
|  | Findings include:   |                                  |                            |        | part of the facility's Preventive   |                  |            |
|  | Based on observation with the Maintenance   |                                  |                            |        | Maintenance Program and   | •                |            |
|  | Director on 08/03/23 at 01:45 p.m., in the office   |                                  |                            |        | document those inspection re  | sults            |            |
|  | supply closet a power strip used to power   |                                  |                            |        | as appropriate. If any issues   |                  |            |
|  | equipment, was not secured, and was dangling  |                                  |                            |        | discovered, they will be addre  |                  |            |
|  | from the outlet on the wall. This condition could   |                                  |                            |        | and resolved immediately. The   |                  |            |
|  | put stress on the power cord causing damage to  |                                  |                            |        | Maintenance Supervisor/design   |                  |            |
|  | the power cord. Ba  | ased on interview at the time of |                            |        | will review with the Administra   | _                |            |
|  | observations, the N   | Maintenance Director agreed      |                            |        | the inspection results.   |                  |            |
|  | the power strip wa  | s dangling, not secured, and     |                            |        | c. The Administrator will   |                  |            |
|  | stated the power strip will need to be mounted or   |                                  |                            |        | monitor adherence to the  |                  |            |
|  | set on the floor.   |                                  |                            |        | Preventative Maintenance  |                  |            |
|  |   |                                  |                            |        | schedule and validate the   |                  |            |
|  |   | re reviewed with the             |                            |        | Preventative Maintenance  |                  |            |
|  | Administrator and   | MD during the exit conference.   |                            |        | documentation is in place.  |                  |            |
|  |   |                                  |                            |        | 4. MONITORING   |                  |            |
|  | 3.1-19(b)   |                                  |                            |        | CORRECTIVE ACTION:  |                  |            |
|  |   |                                  |                            |        | a. The inspection results v   |                  |            |
|  |   |                                  |                            |        | be presented by the Maintena  | ince             |            |
|  |   |                                  |                            |        | Supervisor/designee to the  |                  |            |
|  |   |                                  |                            |        | Administrator monthly and the   | ;                |            |
|  |   |                                  |                            |        | Administrator will present the  |                  |            |
|  |   |                                  |                            |        | inspection results at the mont  | -                |            |
|  |   |                                  |                            |        | Quality Assurance/Performan   |                  |            |
|  |   |                                  |                            |        | Improvement (QA/PI) meeting   | •                |            |
|  |   |                                  |                            |        | Inspection results and system   |                  |            |
|  |   |                                  |                            |        | components will be reviewed the QA/PI Committee with                                  | Dy               |            |
|  |   |                                  |                            |        | subsequent plans of correction  | n                |            |
|  |   |                                  |                            |        | developed and implemented a   |                  |            |
|  |   |                                  |                            |        | deemed necessary to insure  | <i>.</i>         |            |
|  |   |                                  |                            |        | compliance is maintained.   |                  |            |
|  |   |                                  |                            |        | This plan of correction   |                  |            |

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |                                  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  01                                |                                  | (X3) DATE SURVEY<br>COMPLETED   |            |            |
|--|----------------------------------|---|--|----------------------------------|---|------------|------------|
| 155059   |                                  |   | B. WING  |                                  |   | 08/03/2023 |            |
|  | PROVIDER OR SUPPLIER             | I SKILLED NURSING FACILITY, T                       | STREET ADDRESS, CITY, STATE, ZIP COD 1500 GRANT ST HE HUNTINGTON, IN 46750 |                                  |   |            |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIAT   | TE         | COMPLETION |
| TAG  | REGULATORY OR                    | LSC IDENTIFYING INFORMATION                         | TAG  |                                  | DEFICIENCY)   |            | DATE       |
|  |                                  |   |  |                                  | constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/7/2023. | 1          |            |

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