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

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey .eted /2024
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	,	524 AN	ADDRESS, CITY, STATE, ZIP COD NDERSON RD FERFIELD, IN 46017	•	
(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 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	BEIGERGI		DATE
E 0000 Bldg	An Emergency Prepconducted by the Imaccordance with 42 Survey Date: 02/06 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I of Chesterfield Skill not in compliance we Requirements for M Participating Provid 483.73. The facility census of 44 at the to Quality Review con The requirements of Not Met as evidence 403.748(d)(2), 416 441.184(d)(2), 482 443.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requires \$416.54(d)(2), \$448 \$460.84(d)(2), \$488 \$483.475(d)(2), \$488	paredness Survey was diana Department of Health in CFR 483.73. /24 /0524 /55617 /67090 Preparedness survey, Waters led Nursing Facility was found with Emergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR has a capacity of 60 and had a lime of this survey. Inpleted on 02/08/24 // 42 CFR, Subpart 483.73 are led by: // 5.54(d)(2), 418.113(d)(2), // 2.15(d)(2), 483.475(d)(2), // 2.15(d)(2), 485.625(d)(2), // 2.7(d)(2), 485.920(d)(2), // 2.15(d)(2), \$441.184(d)(2), // 3.2.15(d)(2), \$483.73(d)(2), // 3.2.15(d)(2), \$483.73(d)(2), // 3.2.15(d)(2), \$485.68(d)(2), // 3.2.15(d)(2), \$485.920(d)	E 00		DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with the plan of correction constitutes and medicaid requirements.	nn this r he fic red ce	
	•	6.54, CORFs at §485.68, ons" under §485.727,					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	Ξ	TITLE		(X6) DATE

Kimberly Locke HFA 02/26/2024

Any define protectoment and line with an extension (#) denotes a define any which the institution may be expected from correcting providing it is determined.

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617			UILDING	INSTRUCTION	(X3) DATE COMPL 02/06	LETED
	PROVIDER OR SUPPLIEI	R LD SKILLED NURSING FACILITY	·	524 ANI	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		020, RHCs/FQHCs at RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct he emergency plan cility] must do all of the					
		full-scale exercise that is levery 2 years; or					
	1	nunity-based exercise is					
	, ,	onduct a facility-based					
		e every 2 years; or					
	(B) If the [fac	ility] experiences an actual					
		ade emergency that requires					
		mergency plan, the [facility]					
		ngaging in its next required					
		l or individual, facility-based					
		e following the onset of the					
	actual event.						
	` '	Iditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
	1 ' '	s conducted, that may					
		limited to the following:					
	' '	scale exercise that is					
	functional exercis	l or individual, facility-based					
	(B) A mock disast						
		ercise or workshop that is					
		and includes a group					
	discussion using	- · · · · · · · · · · · · · · · · · · ·					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an e	·					
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ergency plan, as needed.					

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Event ID:

RI9F21

Facility ID: 000524

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

PRINTED: 03/04/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	ľ í	UILDING	NSTRUCTION	COMI	E SURVEY PLETED 6/2024		
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	REFERENCED TO THE APPROPRIATE			
	the patient's home conduct exercises plan at least annuithe following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an endage of the community and community and community and community and community are community and community and community and community are community and community are community and community and community are community.	spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not lect an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is leging in its next required full based exercise or individual extional exercise following the gency event. Individual exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a dements, directed pared questions designed							

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

Event ID:

RI9F21

Facility ID: 000524

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	JILDING	NSTRUCTION	(X3) DATE COMPL 02/06 /	ETED
	PROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	524 AN	NDDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, conduct facility-based functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise. (B) A mock disas. (C) A tabletop extenditational exercise. (E) A tabletop extenditational exercise.	nunity-based exercise is not let an annual individual extional exercise; or experiences a natural or lency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the editional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or lercise or workshop led by a ludes a group discussion clinically-relevant line, and a set of problem led messages, or prepared led to challenge an electron of all drills, tabletop hergency events and revise largency plan, as needed. 141.184(d), Hospitals at least \$485.625(d):] PRTF, Hospital, CAH] must less to test the emergency er. The [PRTF, Hospital,				
	CAH] must do the (i) Participate in a that is community	an annual full-scale exercise				

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Event ID:

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Facility ID: 000524

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	LETED
		155617	B. WI	NG		02/06	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017		
	Г						1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	1 ' '	nunity-based exercise is not					
		ct an annual individual,					
	1	tional exercise; or					
	` '	Hospital, CAH] experiences or man-made emergency					
		ation of the emergency					
		is exempt from engaging in					
	• • • • •	ull-scale community based					
	1	ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	· '	at may include, but is not					
	limited to the follo						
		scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	(B) A mo	ck disaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	I -	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	• • •					
	. , ,	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	_	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	30 84(d)·1					
		ou.84(a):j PACE organization must					
	` '	to test the emergency					
	plan at least annu	- -					
	organization must	-					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	l ` '	ict an annual individual,					
		ctional exercise; or					

 STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED 6/2024	
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	<u>-</u>	524 ANI	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Ε	(X5) COMPLETION
TAG	(B) If the PACE ex or man-made eme activation of the e is exempt from en full-scale commun facility-based functional exercise of the emergency of this section is community-based functional exercise of this section is community-based based functional exercise of this section is community-based based functional executed by a facilitator discussion, using clinically-relevant set of problem star messages, or preparation of the pace of the emergency procession of the pace of the pace of the emergency procession of the pace of the pace of the emergency procession of the pace of the pace of the emergency procession of the pace of	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale 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 stements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop nergency events and revise gency plan, as needed. Les at §483.73(d):] Let's must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, he following: an annual full-scale exercise based; or nunity-based exercise is not ict an annual individual,		TAG			DATE

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Event ID:

RI9F21

Facility ID: 000524

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	JILDING	INSTRUCTION	(X3) DATE (COMPL 02/06 /	ETED
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	actual natural or management of the library activation actual natural or management of the library activation actual natural or management activation of the electron of the library activation activation of the library activation of the library activation of the library activation activation of the library activation ac	nan-made emergency that n of the emergency plan, the mpt from engaging its next le community-based or based functional exercise et of the emergency event. Idditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et he [LTC facility] facility's as needed. [483.475(d)]: CF/IID must conduct the emergency plan at least te ICF/IID must do the	IAU			DATE

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

Event ID:

RI9F21

Facility ID: 000524

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED 02/06/2024	
		155617	B. W	ING		02/06/	2024
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	X.			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
		nity-based or individual,					
		tional exercise following the					
	onset of the emergency event. (ii) Conduct an additional annual exercise						
	' '						
	following:	but is not limited to the					
	_	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is					
		and includes a group					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
		emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er						
	_	CF/IID's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's emer	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	; or					
	, ,	ommunity-based exercise					
		conduct an annual					
	-	based functional exercise					
	every 2 years; or.						
		A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer	gency event.					

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

PRINTED: 03/04/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		A. BUILDING COMPLE' B. WING 02/06/2				ETED	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DE ICERCI I		DATE
	1 ' '	ditional exercise every 2 e year the full-scale or					
	1	e under paragraph (d)(2)(i)					
	of this section is c						
		limited to the following:					
		full-scale exercise that is					
	community-based						
	1	ctional exercise; or					
	1	isaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	I -	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	1 ' '	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise ency plan, as needed.					
	The fill A's efficige	elicy plati, as fieeded.					
	*[For OPOs at §48	36.360]					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	•					
		er-based, tabletop exercise					
	· ·	ast annually. A tabletop					
	· ·	a facilitator and includes a using a narrated, clinically					
		cy scenario, and a set of					
	1	its, directed messages, or					
	l •	ns designed to challenge an					
	1 ' '	f the OPO experiences an					
		nan-made emergency that					
	requires activation	of the emergency plan, the					
	-	om engaging in its next					
	required testing exercise following the onset						
	of the emergency						
	1 ' '	PO's response to and					
	maintain documer	ntation of all tabletop					

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Event ID:

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Facility ID: 000524

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155617	B. WING		02/06/2024
		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ANDERSON RD	
WATERS	S OF CHESTERFIE	LD SKILLED NURSING FACILIT		STERFIELD, IN 46017	
				,	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DELICE.KCT/	DATE
		nergency events, and revise			
	needed.	OPO's] emergency plan, as			
	needed.				
	*[RNCHIs at §400	3 7/81.			
		e RNHCI must conduct			
	. , , ,	he emergency plan. The			
	RNHCI must do th	• • •			
		er-based, tabletop exercise			
		A tabletop exercise is a			
		led by a facilitator, using a			
		v-relevant emergency			
	1	et of problem statements,			
		s, or prepared questions			
		enge an emergency plan.			
	_	NHCI's response to and			
		ntation of all tabletop			
	exercises, and em	nergency events, and revise			
	the RNHCI's eme	rgency plan, as needed.			
	Based on record rev	view and interview, the facility	E 0039	E039 – It is the intent of the fa	ocility 03/01/2024
	failed to conduct ex	tercises to test the emergency		to ensure to conduct exercise	s to
	plan at least twice p			test the emergency plan at lea	ast
		drills using the emergency		twice per year, including	
	1 -	C facility must do the		unannounced staff drills using	
	following:			emergency procedures to me	et
		annual full-scale exercise that		set standards.	
	is community-based			1 CORRECTIVE ACTION	S
		ity-based exercise is not		TAKEN:	
		an annual individual,		a On 2/13/24 the	
	facility-based funct			Administrator and the DON/	anaa
		ty experiences an actual natural gency that requires activation		Maintenance Supervisor/desi	yn ee
		lan, the LTC facility is exempt			
		ext required full-scale in a		community-based exercise ar documented the results in the	
	" " "	or individual, facility-based		Safety Binder to meet set	LIIG
	-	l exercise for 1 year following		standards.	
	the onset of the actu	•		2 ALL OTHERS WITH	
		itional exercise that may		POTENTIAL TO BE AFFECT	FD·
		imited to the following:		a All residents and all stat	
	a. A second full-sca	_		and visitors have the potentia	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155617	B. WING		02/06/2024
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹		NDERSON RD	
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		TERFIELD, IN 46017	
	Т		<u> </u>	, <u>.</u>	975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
TAG		or an individual, facility-based	IAG	be affected but none were.	DATE
	functional exercise.			3 MEASURES TO PREVE	:NT
	b. A mock disaster			REOCCURRENCE:	
		ise or workshop that is led by a		a On 2/13/24 the	
	_	ides a group discussion, using		Administrator in serviced the	DON/
		y-relevant emergency scenario,		Maintenance Supervisor/design	
	and a set of problem statements, directed			on the requirement that a full-	_
	messages, or prepar	red questions designed to		community-based exercise m	
	challenge an emerg	ency plan.		be conducted annually and	
	(iii) Analyze the L7	TC facility's response to and		documentation retained to me	eet
	maintain documentation of all drills, tabletop			set standards.	
	exercises, and emergency events, and revise the			b DON/Maintenance	
	LTC facility's emergency plan, as needed in			Supervisor/designee will work	
	accordance with 42 CFR 483.73(d)(2). This			the Administrator to ensure fu	· · ·
	deficient practice co	ould affect all occupants.		scale community-based exerc	cise
				is conducted annually and	
	Findings include:			documentation retained to me	
	D 1 1	tala set.		set standards. If any issues	
		eview with the Maintenance		discovered, they will be addre	essed
		n 02/06/24 at 11:30 a.m., there ation for two table top exercises		and resolved immediately. c The Administrator will	
		1/23 and 10/20/23 but no record		c The Administrator will monitor adherence to the	
		sed exercise or a facility based		Emergency Preparedness Po	licy
	1	Based on interview at the time		Manual and validate the	licy
		he MS agreed that there was		documentation is in place.	
		ired community-based or		4 MONITORING	
		cale exercise conducted within		CORRECTIVE ACTION:	
	the past year.			a At least annually to ensi	ure
				compliance, the Administrator	
	This finding was re	viewed with the MS and		DON/Maintenance	
	Assistant Director of	of Nursing at the exit		Supervisor/designee will revie	ew the
	conference.			Emergency Preparedness Po	licy
				Manual and conduct required	
				exercises and make changes	
				necessary to meet set standa	
				Those reviews will be docume	
				as appropriate. The Administr	
				will present the training result	s at
				the Quality Assurance/	A (DI)
				Performance Improvement (C	(A/PI)

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/06/2024
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	524 AN	ADDRESS, CITY, STATE, ZIP COD NDERSON RD TERFIELD, IN 46017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000				meeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correctic developed and implemented 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 3/1/24.	by on as th
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/06 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety of Chesterfield Skilled not in compliance w Participation in Mes Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	00524 55617	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute admission or agreement by facility of the facts alleged conclusions set forth in this statement of deficiencies. In plan of correction and spec corrective actions are prepared and/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegat of substantial compliance we rederal Medicare and Medicaid requirements.	an this or s The ific ared nce

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY (YOUR SUMMARY STATEMENT OF DEFICIENCIE)		STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The facility has a find detection in the corricorridors and batter the resident sleeping capacity of 60 and hof this survey.	ion and was fully sprinklered. re alarm system with smoke ridors, areas open to the y operated smoke detectors in g rooms. The facility has a had a census of 44 at the time residents have customary			
		ered. All areas providing re sprinklered.			
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.			
	Based on observation failed to ensure 2 of were continuously robstructions. LSC 1 into the required with wheeled equipment, following condition (a) The wheeled equipment clear unobstructed coin.(1525 mm). (b) The health care of training program and wheeled equipment emergency.	on and interview, the facility 64 corridor means of egresses maintained free of 9.2.3.4 (4) states projections dth shall be permitted for provided that all of the	K 0211	k211– It is the intent of the facto ensure corridor means of egress are continuously maintained free of all obstruct to meet set standards. 1 CORRECTIVE ACTIONS TAKEN: a On 2/13/2024 the Maintenance Supervisor/design replaced the PPE carts in two resident halls including to have wheels on them to meet set standards. The Administrator verified the work on 2/13/2024. 2 ALL OTHERS WITH	ions gnee e

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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	
155617		B. WING	02/06/2024		
NAME OF F	DOLUBED OF CLUBNIES		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF F	PROVIDER OR SUPPLIE	R	524 AN	IDERSON RD	
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY	CHEST	ERFIELD, IN 46017	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	following:			POTENTIAL TO BE AFFECTI	ED:
	i. Equipment in use			a All residents and all staf	f
	_	ncy equipment not in use		and visitors have the potential	
		transport equipment		be affected but none were. O	n
	-	tice affects 10 residents in the		2/13/2024 the Maintenance	
	facility.			Supervisor/designee inspecte	d all
				corridors for obstructions and	
	Findings include:			found no other negative findin	-
				3 MEASURES TO PREVE	.NT
		ration during a tour of the		REOCCURRENCE:	
		aintenance Supervisor (MS) on		a On 2/12/24 the	
		o.m. and 01:10 p.m., in two		Administrator inserviced the	
		onal Protective Equipment		Maintenance Supervisor/desig	jnee
	, ,	use but were not equipped		on the requirement to ensure	
		ng the carts to be moved out of		means of egress are continuo	•
	_	emergency. The PPE carts were		maintained free of all obstruct	
	1	108 and 211. Based on an		to meet set standards. On 2/2	
		ne of observations, the MS		the Administrator inserviced the	
		s are not equipped with wheels		staff on the requirement to en	
	but I can install wh	eels to them.		means of egress are continuo	•
	TTI (* 1:	the state of the state of		maintained free of all obstruct	ions
	_	viewed with the Assistant		to meet set standards.	
	I -	g and the MS during the exit		b Maintenance	
	conference.			Supervisor/designee will inspe	
	2.1.10(1.)			all corridors weekly to ensure	- I
	3.1-19(b)			are continuously maintained fi	
				of all obstructions as a part of	
				facility's Preventive Maintenar	
				Program and document those	
				inspection results as appropri	
				If any issues are discovered, t	-
				will be addressed and resolve	
				immediately. The Maintenand	
				Supervisor/designee will revie	·w
				with the Administrator the	
				inspection results.	
				c The Administrator will	
				monitor adherence to the	
	l		1	Preventative Maintenance	

schedule and validate the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETE				
		155617	B. WII	NG		02/06/	2024
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY			524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results w be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/1/24.	nce nly ce oy n	
K 0353 SS=F		Maintenance and Testing					
Bldg. 01	Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	Maintenance and Testing ar and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 02/06/2024 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (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 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility K 0353 K353 - It is the intent of the 03/01/2024 failed to maintain automatic sprinkler systems in facility to ensure to maintain the accordance with NFPA 25. LSC 9.7.5 requires all automatic sprinkler system in sprinkler systems shall be inspected, tested, and accordance with NFPA 25 to meet maintained in accordance with NFPA 25, Standard set standards. for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1.CORRECTIVE ACTIONS 2011 Edition, Section 4.1.4.1 states the property TAKEN: owner or designated representative shall correct 1.On 2/26/24 the Maintenance Supervisor/Designee or repair deficiencies or impairments that are found during the inspection, test and maintenance will obtain the paperwork from the required by this standard. Corrections and repairs facilities licensed sprinkler shall be performed by qualified maintenance contractor on the 5-year internal personnel or a qualified contractor. NFPA 25, pipe inspection and documented 4.3.1 requires records shall be made for all the results in the Life Safety inspections, tests, and maintenance of the system Binder to meet set standards. components and shall be made available to the 2.ALL OTHERS WITH authority having jurisdiction upon request. This POTENTIAL TO BE AFFECTED: deficient practice could affect all residents, staff, 1.All residents and all staff and visitors in the facility. and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT** Findings include:

Based on review of "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 03/17/20 during record review with the Maintenance Supervisor (MS) at 12:10 p.m. on 02/06/24, the 5 year internal pipe inspection documentation recommended the sprinkler system be flushed. Based on interview at the time of record review, the MS stated the flush was completed by the previous company with qualified staff but

REOCCURRENCE:

The Administrator in serviced the Maintenance Supervisor that deficiencies noted on the five-year internal pipe inspection must be completed and documented to meet set standards.

1.Maintenance Supervisor/designee will ensure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/06/2024	
NAME OF PROVIDER OR SUPPLI	ER ELD SKILLED NURSING FACILIT	524 AN	ADDRESS, CITY, STATE, ZIP COD IDERSON RD FERFIELD, IN 46017		
PREFIX (EACH DEFICIE TAG REGULATORY O	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION as not available for review.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) the sprinkler systems are	(X5) COMPLETION DATE	
This finding was a	reviewed with the Assistant and MS at the exit conference.		the sprinkler systems are maintained and necessary test is performed on the sprinkler system as a part of the facility monthly Preventive Maintenar Program and document those inspection results as appropriated any issues are discovered, the will be addressed and resolve immediately. The Maintenant Supervisor/designee will review with the Administrator the inspection results. 2. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 1. MONITORING CORRECT ACTION: 1. The inspection results to be presented by the Maintenan Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allocation of compliance with allocation	i's ince late. hely do late will ince late. h	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 02/06/2024			
	PROVIDER OR SUPPLIER OF CHESTERFIE	LD SKILLED NURSING FACILITY	524 AN	ADDRESS, CITY, STATE, ZIP COD IDERSON RD FERFIELD, IN 46017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using of complies with NFF Code, electrical words are recomplied in the service provided in	Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 ation and interview, the facility extrical wirings were protected. Ition. Article 406.5 (F) Exposed cles shall be enclosed so that les are not exposed to contact. Itice could affect staff, residents		all regulatory requirements. Our date of compliance is 3/1/24. K511 – It is the intent of the facility to ensure electrical wiri are protected and to ensure electrical panels in the halls ar secured from non-authorized personnel to meet set standar. 1.CORRECTIVE ACTIONS TAKEN: a On 2/15/24 the Maintena Supervisor replaced the outsid electrical receptacle and electrical recepta	ngs re ds. ance de rical et
		e ran into it. viewed with the Assistant and MS at the exit conference.		1.All residents and all sta and visitors have the potential be affected but none were. 2.MEASURES TO PREVENT	ff to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
155617			B. WIN	NG		02/06/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017		
					, · · · · · · · · · · · · · · · · · · ·	ı	OUE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL	1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION ation and interview, the facility		IAG	1.On 2/12/24 the		DATE
		f 2 electrical panel in the 100					
		-			Administrator inserviced the		
		om non-authorized personnel. tion states 230.62 Energized			Maintenance Supervisor/desig	jnee	
		_			on the requirement to ensure	.	
		ipment shall be enclosed as			electrical wirings are protected	^{1,}	
	_	(A) or guarded as specified in			including outside electrical		
	230.62(B).	gizad narta shall be analoged			receptacles, and ensure all		
		gized parts shall be enclosed			electrical panels are secured f		
		t be exposed to accidental			non-authorized personnel to n	ieet	
		guarded as in 230.62(B).			set standards. 2.Maintenance		
	` '	a switchboard, panelboard, or					
					Supervisor/designee will ensu		
	-	uarded in accordance with			electrical wirings are protected	^{1,}	
		Where energized parts are			including outside electrical		
	-	d in 110.27(A)(1) and (A)(2), a			receptacles, and ensure all		
	_	or sealing doors providing	electrical panels are secured from				
		parts shall be provided. This			non-authorized personnel as a	-	
	in the 100 hall.	ould affect staff and residents			of the facility's monthly Prever	ılive	
	in the 100 han.				Maintenance Program and		
	Eindings in abida.				document those inspection res		
	Findings include:				as appropriate. If any issues		
	Događan obsamjetic	on with Maintenance			discovered, they will be addre		
		on with Maintenance 102/06/24 at 12:30 p.m., an			and resolved immediately. Th		
		ne 100 hall was unlocked when			Maintenance Supervisor/desig	· I	
	•				will review with the Administra	tor	
	-	cluded breakers to the lights,			the inspection results.		
		, and outlets in the 100 hall. at the time of observation, the			3.The Administrator will		
		rical panel will need to be			monitor adherence to the Preventative Maintenance		
	locked.	icai panci wili need to be			schedule and validate the		
	iockeu.				Preventative Maintenance		
	This finding was ===	viewed at the exit conference					
	_	ssistant Director of Nursing.			documentation is in place. 3.MONITORING CORRECT	N/E	
	with the Mis and As	sistant Director of Nursing.			ACTION:	IVE	
	3.1-19(b)					A/ill	
	J.1-17(0)				1.The inspection results to		
					be presented by the Maintena	IIC C	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	ııy	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/06/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY		524 AN	STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0761 SS=F Bldg. 01	facility failed to east testing of fire door accordance of LSC openings in dividing 19.1.1.4.1 shall be pushall be protected be door assemblies. (S 8.3.3.1 Openings researched by Table 8.3. approved, listed, lal fire window assembly hardware, including anchorage, and sills requirements of NF and Other Opening otherwise specified states fire door asset tested not less than	eview, and interview, the sure annual inspection and assemblies were completed in 19.1.1.4.1.1 communicating g fire barriers required by bermitted only in corridors and y approved self-closing fire ee also Section 8.3.) LSC quired to have a fire protection 4.2 shall be protected by beled fire door assemblies and blies and their accompanying g all frames, closing devices, in accordance with the PA 80, Standard for Fire Doors Protectives, except as in this Code. NFPA 80 5.2.1 mblies shall be inspected and annually, and a written record all be signed and kept for	K 0761	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 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 3/1/24. K761 – It is the intent of the facility to ensure annual insperant testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4. communicating openings in dividing fire barriers required 19.1.1.4.1 shall be permitted in corridors and shall be proted by approved self-closing fire of assemblies to meet set standards. 1 CORRECTIVE ACTION TAKEN: a On 11/9/23 the Mainten Supervisor/designee conduct the annual inspection for the door assemblies and docume the itemized inspection result the Annual Door Inspections	g. n by on as th 03/01/2024 ection 1.1 by only ected door S ance ed fire ented s on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>01</u>			COMPLETED	
		155617	B. W	ING		02/06/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	1			IDERSON RD			
\\\\ATER	S OF CHESTERFIE	LD SKILLED NURSING FACILITY	,		TERFIELD, IN 46017			
WATER		ED GRIELED NORGING I AGIEIT		OFFICE				
(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 APPROPRI	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		HJ. NFPA 80, 5.2.4.1 states fire			meet set standards. The			
		ll be visually inspected from			Administrator verified the			
		the overall condition of door			inspections and documentation	on on		
	I -), 5.2.4.2 states as a minimum,			2/13/24.			
	the following items				2 ALL OTHERS WITH			
		or breaks exist in surfaces of			POTENTIAL TO BE AFFECT			
	either the door or fr				a All residents and all sta			
		light frames, and glazing beads			and visitors have the potentia	al to		
		ely fastened in place, if so			be affected but none were.			
	equipped.				3 MEASURES TO PREVE	ENT		
		, hinges, hardware, and			REOCCURRENCE:			
		eshold are secured, aligned,			a On 2/12/24 the			
	and in working orde	er with no visible signs of			Administrator/Corporate Prop	erty		
	damage.				Manager inserviced the			
	(4) No parts are mis				Maintenance Supervisor/desi	ignee		
	` '	do not exceed clearances			on the requirement that annu	al		
	listed in 4.8.4 and 6				testing & inspections of fire de	oor		
		device is operational; that is,			assemblies must be conducted	ed to		
	the active door com	pletely closes when operated			ensure proper operation and			
	from the full open p				itemized and documented on	the		
		is installed, the inactive leaf			Annual Door Inspections log	to		
	closes before the ac	tive leaf.			meet set standards.			
		are operates and secures the			b Maintenance			
	door when it is in the	-			Supervisor/designee will cond	duct		
		vare items that interfere or			the annual inspection of fire of	door		
	prohibit operation a	re not installed on the door or			assemblies to ensure proper			
	frame.				operation and document the			
	1 1	ications to the door assembly			itemized inspection results or	n the		
	_	ed that void the label.			Annual Door Inspection log a	s a		
	` '	edge seals, where required, are			part of the facility's Preventive	е		
		their presence and integrity.			Maintenance Program and			
	This deficient pract	ice could affect all residents.			document those inspection re	esults		
					as appropriate. If any issues	s are		
	Findings include:				discovered, they will be addre	essed		
					and resolved immediately. T	he		
	Based on record rev	riew with the Maintenance			Maintenance Supervisor/desi	ignee		
	Supervisor (MS) on	02/06/24 at 11:30 a.m.			will review with the Administra	ator		
	documentation of a	n annual inspection for the fire			the inspection results.		1	

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door assemblies was available for review was

completed 11/09/23 but was not itemized. Based

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The Administrator will

monitor adherence to the

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617						
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY			524 AN	ADDRESS, CITY, STATE, ZIP COD IDERSON RD "ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION time of records review, the MS	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Preventative Maintenance	ATE	(X5) COMPLETION DATE
	stated the annual fit completed but was itemized This finding was re	time of records review, the MS re door inspection was unaware that it must be eviewed with the Assistant g and MS at the exit conference.		Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month 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 3/1/24.	hly ce J. by	

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