

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

PRINTED: 05/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/10/2023
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the investigation of Complaint Number IN00406281 that exited on 04/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>This visit was in conjunction with a 2nd Post Survey Revisit (PSR) which was conducted for the 1st PSR survey that was exited on 04/17/23 for the Life Safety Code Recertification survey that exited on 02/28/23</p> <p>Complaint IN00406281 - Corrected</p> <p>Survey Date: 05/10/23</p> <p>Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980</p> <p>At this Complaint PSR survey, The Waters of Wakarusa Skilled Nursing Facility was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility is partially protected by a diesel-powered 230 kW emergency generator.</p>	{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	<p>Continued From page 1</p> <p>The facility has 133 certified beds. 109 are dually certified for Medicare and Medicaid; 24 are certified for Medicare only. At the time of the survey, the census was 103.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/10/23</p>	{K 000}			