PRINTED: 05/22/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	A. B	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  05/01/2024	
	PROVIDER OR SUPPLIER			300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST			
WATER	S OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE	WAKA	RUSA, IN 46573			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COR		1	(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	COMPLETION	
F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
E 0000 Bldg	conducted by the In accordance with 42  Survey Date: 05/01  Facility Number: 00 Provider Number: 1  AIM Number: 100  At this Emergency Waters of Wakarus found not in complipereparedness Required Medicaid Participate CFR 483.73  The facility has 133 certified for Medical certified for Medical Survey, the census version of the survey of t	224 200521 255582 266980  Preparedness survey, The a Skilled Nursing Facility was fance with Emergency frements for Medicare and fing Providers and Suppliers, 42 3 certified beds. 109 are dually fare and Medicaid; 24 are fare only. At the time of the	EO	000	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. plan of correction and spec corrective actions are prepand/or executed in complia with state and federal laws This plan of correction constitutes a written allegated of substantial compliance of substantial compliance of substantial requirements.	an y this or is The cific pared ance		
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All	416.54(a)(1)-(2), 418.113(a) )(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) )(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)  Hazards Risk Assessment ), §416.54(a)(1)-(2),						

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

§418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),

> TITLE (X6) DATE

Roberta Shull Scott 05/20/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T4ND21 Facility ID: 000521 If continuation sheet Page 1 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>	COMPL OF/O1	
		155582	B. W	ING		05/01/2024	
NAME OF I	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP COD		
VA/A TED					VASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, T	HE 	WAKAR	RUSA, IN 46573		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!		DATE
		?), §485.727(a)(1)-(2), ?), §486.360(a)(1)-(2),					
		, §494.62(a)(1)-(2)					
	[(a) Emergency Plan. The [facility] must						
	develop and maintain an emergency						
		n that must be reviewed,					
	and updated at least every 2 years. The plan must do the following:]						
	must do trie ioliov	virig.]					
	(1) Be based on and include a documented,						
	facility-based and community-based risk						
assessment, utilizing an all-hazards							
	approach.*						
	(2) Include strate	gies for addressing					
		s identified by the risk					
	assessment.	o radinanda by and new					
		t §418.113(a):] Emergency					
	· ·	e must develop and					
		gency preparedness plan					
		ewed, and updated at least e plan must do the					
	following:	e plan must do me					
	_	and include a documented,					
	facility-based and	community-based risk					
	assessment, utiliz	zing an all-hazards					
	approach.						
	` '	gies for addressing					
		s identified by the risk uding the management of					
		s of power failures, natural					
	-	ner emergencies that would					
		s's ability to provide care.					
	·	• .					
	*[For LTC facilities	- , , -					
		The LTC facility must					
	-	ntain an emergency					
	i preparedness pla	n that must be reviewed,					

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Event ID:

T4ND21 Facility ID: 000521

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PRINTED: 05/22/2024

				TRINTED. 03/22/2021		
EPARTMENT OF HEALTH AND HUN	MAN SERVICES			FORM APPROVED		
ENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
	155582	B. WING		05/01/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST			
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			WAKARUSA, IN 46573			

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and updated at least annually. The plan must do the following:  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.  (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.  (2) Include strategies for addressing emergency events identified by the risk assessment.  Based on record review and interview, the facility		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
	failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.  Findings include:  Based on records review with the Maintenance Director and the Administrator on 05/01/24 at 10:45 a.m., The Hazardous Vulnerability Assessment (HVA) which is used to determine		to ensure to maintain an emergency preparedness plan that is based on and includes a documented, facility based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73 (a) to meet set standards.  1 CORRECTIVE ACTIONS TAKEN: a On	

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Event ID:

T4ND21 Facility ID: 000521

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PRINTED: 05/22/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<del></del>	COMPLETED 05/01/2024	
		155582	B. W	ING			
NAME OF B	DROLUDED OD CLUDDLIE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIE	K		300 N V	WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	IE 	WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	community-based risks was left			05/11/2024	the	
	· ·	documentation could be			Maintenance Supervisor, DOI		
		risk assessment utilizing the			the Administrator filled out the	)	
		ch. Based on an interview at review, the Maintenance			hazardous vulnerability	41	
		dministrator stated a risk			assessment and documented information in the facilities	ıne	
						doro	
	assessment utilizing an all-hazards approach was not completed.				Emergency Preparedness bir located at the nurse's station		
	not completed.				all other areas to meet set	anu	
	This finding was re	eviewed with the Maintenance			standards. The Administrato	r	
	_	dministrator during the exit			verified the work05/11/		
	conference.	diffinistrator during the exit			2 ALL OTHERS WITH	27	
					POTENTIAL TO BE AFFECT	FD <sup>.</sup>	
					a All residents and all staf		
					and visitors have the potentia		
					be affected but none were.		
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
					a On		
					05/23/2024	_ the	
					Administrator Inserviced the		
					Maintenance		
					Supervisor/DON/designee on	the	
					requirement that a hazardous		
					vulnerability assessment mus		
					filled out and documented in t	he	
					facilities Emergency		
					Preparedness binders located	d at	
					the nurse's station and all oth	er	
					areas to meet set standards.		
					b On		
					05/23/2024	_ the	
					Administrator/Maintenance		
					Supervisor/DON Inserviced a	II staff	
					on the updated Emergency	1 -4	
					Preparedness binders located		
					the nurses station and all other	er	
					areas to meet set standards.		
					c The Maintenance	/ -!	
					Supervisor/DON/Administrato	r/des	

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/01/2024
	ROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TH	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 APPROPR DEFICIENCY)	5.112
				ignee will ensure a hazardou vulnerability assessment mustilled out and documented in facilities Emergency Preparedness Binder to mee standards.  d The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place.  4 MONITORING CORRECTIVE ACTION: a The Administrator and Maintenance Supervisor/DON/designee w review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrat present the training results a Quality Assurance/ Performa Improvement (QA/PI) meetin Results and system componivill be reviewed by the QA/P Committee with subsequent of correction developed and implemented as 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 is5/28/2024	st be the the triangle state the sta

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Event ID:

**T4ND21** Facility ID: 000521

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		X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<del></del>	COMPL		
		155582	B. WI	NG		05/01/2024		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
		SKILLED NURSING FACILITY, THE	≣		VASHINGTON ST RUSA, IN 46573			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0031	, , , ,	5.54(c)(2), 418.113(c)(2),						
SS=C	` , ` , `	2.15(c)(2), 483.475(c)(2),						
Bldg		102(c)(2), 485.625(c)(2),						
	485.68(c)(2), 485.727(c)(2), 485.920(c)(2) 486.360(c)(2), 491.12(c)(2), 494.62(c)(2)							
		als Contact Information						
		416.54(c)(2), §418.113(c)(2),						
	. , , , .	460.84(c)(2), §482.15(c)(2),						
	. , , , .	33.475(c)(2), §484.102(c)(2),						
	- ,,,,	35.625(c)(2), §485.727(c)(2),						
		486.360(c)(2), §491.12(c)(2),						
	§494.62(c)(2).							
	an emergency preplan that complies local laws and mu at least every 2 ye facilities]. The coninclude all of the form	nust develop and maintain eparedness communication s with Federal, State and est be reviewed and updated ears [annually for LTC enmunication plan must collowing: eation for the following: tribal, regional, and local						
	emergency prepar	_						
	(ii) Other sources							
	*[For LTC Facilitie Contact informatio (i) Federal, State, emergency prepar (ii) The State Licer Agency.	es at §483.73(c):] (2) on for the following: tribal, regional, and local redness staff. nsing and Certification he State Long-Term Care						
	information for the	tribal, regional, and local						

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Event ID:

T4ND21 Facility ID: 000521

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	COMPLETED	
		155582	B. WI	NG		05/01/2024		
		1	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			WASHINGTON ST			
WATERS	S OF WAKARUSA	SKILLED NURSING FACILITY, TH	E	1	RUSA, IN 46573			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(ii) Other sources							
	1 ' '	ensing and Certification						
	Agency.	to ation and Advance.						
		tection and Advocacy						
	Agency.	view and interview, the facility	E 00	)21	<b>E031</b> It is the intent of the fa	cility	05/28/2024	
		emergency preparedness	EU	)31	<b>E031</b> – It is the intent of the facility to ensure the emergency		03/26/2024	
	communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance				preparedness communication	nlan		
					includes contact information for	•		
					the following: federal, State, tr			
					regional or local emergency	ibai,		
					preparedness staff, the state			
					licensing and certification age	ncy,		
		42 CFR 483.73(c) (2). This			the office of the state long terr	-		
	deficient practice c	ould affect all occupants.			care ombudsman, other source			
					of assistance in accordance w	/ith		
	Findings include:				42 CFR 483.73©(2) to meet s	et		
					standards.			
		eview with the Maintenance			1 CORRECTIVE ACTIONS	S		
		dministrator on 05/01/24 at			TAKEN:			
	_	vided forms for Federal, State,			a On 5/11/2024 the			
		ncy contacts were left blank.			Administrator and the			
		State Licensing and			Maintenance Supervisor/design	gnee		
	_	cy, The Office of the State			reviewed and updated the			
		mbudsman, and other sources d on an interview at the time of			emergency preparedness	0		
		Maintenance Director and the			communication plan includes contact information for the	<b>Z</b>		
	•	ed the emergency contact list				hal		
	was no filled out.	ed the emergency contact list			following: 1. Federal, state, tri regional, or local emergency	uai,		
	was no micu out.				preparedness staff, 2.the state	ے	1	
	This finding was re	eviewed with the Maintenance			licensing and certification age			
	_	dministrator during the exit			3. The office of the state long	•		
	conference.				care ombudsman 4. Other	.3		
					sources of assistance in			
					accordance with 42 CFR 483.	73(c)	1	
					to meet set standards.	` '	1	
					2 ALL OTHERS WITH		1	
					POTENTIAL TO BE AFFECTI	ED:		
					a All residents and all staf	f	1	
					and visitors have the potential	to		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING	<del></del>	COMPLETED	
		155582	B. W			05/01/20	J24
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\\\\		NULLED MUDGING EACH ITY THE	_		WASHINGTON ST		
WATERS	OF WANAKUSA S	SKILLED NURSING FACILITY, THE	<u> </u>	WAKAF	RUSA, IN 46573		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					be affected but none were.  3 MEASURES TO PREVE	NIT	
					REOCCURRENCE:	NI	
					a On 5/23/2024 the		
					Administrator Inserviced the		
					DON/Maintenance		
					Supervisor/designee on the		
					requirement to ensure to revie	w	
					and update the emergency		
					preparedness communication		
					includes 2 contact information		
					the following: 1. Federal, state		
					tribal, regional, or local emerg		
					preparedness staff, 2.the state		
					licensing and certification age	-	
					3. The office of the state long	term	
					care ombudsman 4. Other		
					sources of assistance in accordance with 42 CFR 483.	73(a)	
					to meet set standards.	73(0)	
					b DON/Maintenance		
					Supervisor/designee will work	with	
					the Administrator to ensure to		
					review and update the emerge	ency	
					preparedness communication	-	
					includes 2 contact information	for	
					the following: 1. Federal, state	,	
					tribal, regional, or local emerg	-	
					preparedness staff, 2.the state		
					licensing and certification age	-	
					3. The office of the state long	term	
					care ombudsman 4. Other		
					sources of assistance in	73(0)	
					accordance with 42 CFR 483.	` ′	
					to meet set standards. If any issues are discovered, they wi		
					addressed and resolved	ıı De	
					immediately.		
					c The Administrator will		
					monitor adherence to the		

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Event ID:

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED 05/01/2024
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, T	300	EET ADDRESS, CITY, STATE, ZIP COD O N WASHINGTON ST AKARUSA, IN 46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE APPRO	ON (X5) DE COMPLETION PRIATE DATE
				Emergency Preparedness Manual and validate the documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a At least annually to e compliance, the Administration DON/Maintenance Supervisor/designee will resemine the Emergency Preparedness Manual and conduct requirexercises and make changenecessary to meet set stare. Those reviews will be documented as appropriate. The Admin will present the training resemble the Quality Assurance/Performance Improvemented meeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requiremented our date of compliance is 5/28/2024	nsure ator and eview the Policy ed les as adards. Immented istrator cults at ed by etion ed as are
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	Preparation and/or execu of this plan of correction general, or this corrective action, does not constitut	in e

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Event ID:

T4ND21

Facility ID: 000521

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155582	B. WI	NG		05/01/	2024
				CTDEET A	DDDEGG CITY CTATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST		
\A/ATEDO		NULLED NUDSING FACILITY THE	_				
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THE	=	WAKAK	RUSA, IN 46573		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
					admission or agreement by t	his	
	Survey Date: 05/01	/24			facility of the facts alleged or		
	,				conclusions set forth in this		
	Facility Number: 0	00521			statement of deficiencies. The	ne l	
	Provider Number: 155582 AIM Number: 100266980				plan of correction and specif	-	
					corrective actions are prepar		
	111111111111111111111111111111111111111				and/or executed in compliance		
	At this Life Safety Code survey, The Waters of Wakarusa Skilled Nursing Facility was found not in compliance with Requirements for Participation				with state and federal laws.	~	
					This plan of correction		
					constitutes a written allegation	,	
	_	aid, 42 CFR 483.90(a), Life			of substantial compliance wi		
	Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing				Federal Medicare and		
					Medicaid requirements.		
					medicala requirements.		
	Health Care Occupa						
	Treatin Cure Occupi	anoles.					
	This one story facili	ity was determined to be of					
		ruction and was fully					
		cility has a fire alarm system					
	-	on in the corridors and in areas					
		rs. 73 resident rooms were					
	_	ry operated smoke detectors.					
	The facility is partia						
	• •	kW emergency generator. The					
	•	ified beds. 109 are dually					
		are and Medicaid; 24 are					
		are only. At the time of the					
		•					
	survey, the census v	vas 67.					
	O1:4 D:						
	Quality Review con	npieted on 03/08/24					
K 0131	NFPA 101						
SS=E	Multiple Occupand	cios					
Bldg. 01		cies - Sections of Health					
Diag. 01	Care Facilities	Sica - Occuona di Hedilii					
		care facilities classified as					
	other occupancies	s meet all of the following:					
	o Thou are not in	tanded to serve four or					
	-	tended to serve four or					
	more inpatients for purposes of housing,						

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

f '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
	155582	B. WI	NG		05/01/	2024
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA S	KILLED NURSING FACILITY, THE		300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
WATERS OF WAKARUSA S  (X4) ID SUMMARY S  PREFIX (EACH DEFICIENCY REGULATORY OR  treatment, or custor on They are separated accordance with on The entire build by an approved, sure automatic sprint with Section 9.7.  Hospital outpatient required to be class Health Care Occup number of patients 19.1.3.3, 42 CFR 44 Based on observation failed to ensure 1 of doors were self-closs LSC 8.3.3.3 states us doors shall be self-class automatic-closing in deficient practice conners on esmoke compartry.  Findings include:  Based on observation Director on 05/01/24 that separated Health was self-closing but when tested. Based on observation, the Mais separation fire door frame and would not self-closing and would not self-closing in deficient practice for on the process of t	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION omary access. ated from areas of health by ving a minimum two hour ng in h Chapter 8. ling is protected throughout upervised kler system in accordance a surgical departments are sified as an Ambulatory coancy regardless of the a served. B82.41, 42 CFR 485.623 In and interview, the facility 1 occupancy separation fire ing and latch into the frame. Inless otherwise specified, fire losing/latching or accordance with 7.2.1.8. This uld affect all 25 residents in ment.  In with the Maintenance at 12:31 a.m., the fire door heare from Assisted Living did not latch into the frame on interview at the time of intenance Director stated the was rubbing on the door t self-latch.		300 N W WAKAR ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  K131— It is the intent of the fact to ensure occupancy separation fire doors are self-closing and latch into the frame to meet set standards.  1 CORRECTIVE ACTIONS TAKEN:  a On _5/21/2024 the Maintenance Supervisor/design repaired the fire door that separated healthcare from assisted living to ensure itself closes and latches into the frame to meet set standards. The Administrator verified the repair to meet set standards. The Administrator verified the repair 5/23/2024.  2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff and visitors have the potential	cility on tt cinee ir on to	(X5) COMPLETION DATE  05/28/2024
The findings were re Administrator and M the exit conference.	Seriewed with the Maintenance Director during			be affected but none were. Or 05/21/2024. the Maintenance Supervisor/designee inspected other areas and found no other	d all	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155582	B. WI	NG		05/01/	/2024
		•	•	STREET.	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	₹		300 N \	WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	E	WAKAI	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	3.1-19(b)				negative findings.	NT	
					3 MEASURES TO PREVE REOCCURRENCE:	IN I	
					a On 05/23/204 the		
					Administrator Inserviced the		
					Maintenance Supervisor on th	e	
					requirement to ensure to provi		
					fire doors that would limit the		
					spread of fire and to ensure th	еу	
					self-close and latch fully into t	-	
					frame to meet set standards.		
					b Maintenance		
					Supervisor/designee will inspe		
					all doors throughout the facility		
					monthly to ensure they would		
					the spread of fire and to ensur		
					they close and latch as a part	of	
					the facility's Preventive		
					Maintenance Program and		
					document those inspection res		
					as appropriate. If any issues discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra		
					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:	:11	
					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	nlv	

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING		COMI	(X3) DATE SURVEY COMPLETED 05/01/2024		
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	;	STREET ADDRESS, CITY, STATE, ZII 300 N WASHINGTON ST WAKARUSA, IN 46573	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID PROVIDER'S PLAN OF C EFIX (EACH CORRECTIVE ACTION) CROSS-REFERENCE TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to ensure 1 of continuously in pro- NFPA 72, National 2010 Edition, Section defects and malfund	n - Testing and n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 034	Quality Assurance/P Improvement (QA/PI Inspection results an components will be r the QA/PI Committee subsequent plans of developed and imple deemed necessary t compliance is mainta This plan of correct constitutes our cree allegation of compli all regulatory requir Our date of complia 05/28/2024	ind system reviewed by re with correction remented as reviewed ented as reviewed by re with correction remented as reviewed by re with remented as reviewed by reviewed as rev	05/28/2024

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standards. The Administrator

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	OF CORRECTION	IDENTIFICATION NUMBER  155582	A. BUILDING 01  B. WING		COMPLETED 05/01/2024	
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(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	
	panel with the Main at 1:03 p.m., the timindicated the time at 1:03 p.m. Based on observation, the Mafire alarm control part.  The finding was rev	on of the fire alarm control tenance Director on 05/01/24 te on the fire alarm control panel is 1:53 p.m. when checked at interview at the time of intenance Director agreed the anel had the wrong time.  iewed with the Maintenance istrator during the exit		verified the work on 05/03/202  ALL OTHERS WITH POTENTIAL TO BE AFFECTI  a All residents and all staf and visitors have the potential be affected but none were.  3 MEASURES TO PREVE REOCCURRENCE: a On 05/23/2024 the Administrator in serviced the Maintenance Supervisor/desig on the requirement to ensure alarm systems are continuous proper operating condition and fire alarm control panel displat the correct time to meet set standards. b Maintenance Supervisor/designee will ensure fire alarm systems are continuously in proper operatic condition and the fire alarm con panel displays the correct time a part of the facility's monthly Preventive Maintenance Prog and document those inspection results as appropriate. If any issues are discovered, they we addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	ED:  If  Ito  INT  Ignee  Ifire  Ignee  Ifire  Ignee  Ifire  Ignee  Ifire  Ignee  Ifire  Ignee  Ifire  Ignee  Igne	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/01/2024
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 0353 SS=F Bldg. 01		- Maintenance and Testing - Maintenance and Testing		4 MONITORING CORRECTIVE ACTION: a The inspection results to be presented by the Mainten. Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mon Quality Assurance/Performar Improvement (QA/PI) meetin 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 will regulatory requirements. Our date of compliance is 05/28/2024	e thly nce g. n by on as
g.	Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location are	er 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 lid readily available.			
	b) Who provided	system last checked system test			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							ORM APPROVED MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	III TIDI E C	ONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	, ,	PLETED
MIDIEMI	or conduction	155582	B. W		01		1/2024
		100002	Б. 11			03/0	1/2024
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
	ne vibbit on boll bib			300 N	WASHINGTON ST		
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE	WAKA	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	c) Water system	supply source					
	Provide in PEMAI	 RKS information on					
		non-required or partial					
	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25						
		view and interview, the facility	V O	353	K353– It is the intent of the fa	cility	05/28/2024
	failed to maintain 1 of 1 automatic sprinkler		KU	1333	to ensure to maintain the	Cility	03/26/2024
		5 requires all sprinkler systems			automatic sprinkler systems to	0	
	1 -				meet set standards.	O	
	shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the				1 CORRECTIVE ACTION	9	
		, and Maintenance of			TAKEN:	3	
		Protection Systems. NFPA 25,			a On 05/20/2024 the facili	ities	
		on 5.3.4.1.2 states the			licensed sprinkler contractor	ilies	
	· ·	tifreeze solution shall be			adjusted the freeze protection	on	
		num necessary for the			the sprinkler system to meet		
		m temperature. NFPA 25, 4.3.1			standards. The Administrator		
	_	all be made for all inspections,			verified the work on		
	_	nce of the system components			05/20/2024		
		available to the authority			2 ALL OTHERS WITH		
		upon request. This deficient			POTENTIAL TO BE AFFECT	FD·	
		et all residents, staff, and			a All residents and all stat		
	visitors.	et all residents, starr, and			and visitors have the potentia		
	1333033				be affected but none were.	110	
	Findings include:				3 MEASURES TO PREVE	NT	
	I mumgs meruus				REOCCURRENCE:	-141	
	Based on review of	the facility's annual sprinkler			a On 05/23/2	2024	
		eport with the Maintenance			the Administrator		
		nistrator on 05/01/24 at 09:57			Inserviced the Maintenance		
		rinkler report dated 12/20/23			Supervisor/designee on the		
	_	ting point for the antifreeze			requirement to ensure to main	ntain	
		renheit. The reference section			the sprinkler systems and ens		
	_	gure A.5.3.4.1 Isothermal Lines -			the low testing point for the		
	1	Iean Temperature (Fahrenheit.)			antifreeze is -10 Fahrenheit to	)	
	1	owest temperature for the			meet set standards.		
		Fahrenheit. Based on an			b Maintenance		

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interview at the time of record review, the

can get below -3 degrees in the winter.

Maintenance Director agreed the antifreeze was

tested at -3 degrees and stated the facility location

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Supervisor/designee will ensure

that the facilities licensed sprinkler

contractor will maintain the freeze

protection on the sprinkler system

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/01/2024	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	E	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(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)	TE	(X5) COMPLETION DATE
	The findings were r Administrator and M the exit conference. 3.1-19(b)	eviewed with the Maintenance Director during			as a part of the facility's quarter Preventive Maintenance Progrand document those inspection results as appropriate. If any issues are discovered, they will addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.  c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The inspection results where the preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The inspection results where the inspection results at the month 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 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	ill be ill nce hlyce hyce hyce hyce hyce hyce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       05/01/2024			ETED		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	ŀΕ	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postriers shall be postriem wall. Smoke in duct penetration systems where an is installed for smote to the smoke barrian system in REMAR Based on observation interview, the facility barrier walls were considered according to the autonomic to the smoke barrian system in REMAR Based on observation interview, the facility barrier walls were considered according to the autonomic to the autonomic to the autonomic to the same set forth in ASTM I for Fire Tests of Building Content approved test methods approved test methods approved test methods approved the system or divide the state of Throught State of Thr	pall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an ele dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.  ) hanical smoke control eKS.  Ons, records review, and ty failed to ensure 2 of 8 smoke constructed to requirements hority having jurisdiction states the fire resistance of and building assemblies shall cordance with test procedure E 119, Standard Test Methods ilding Construction and Materials; methods; or analytical by the AHJ. The AHJ requires ke barriers to be sealed with a evice tested in accordance Standard Test Method for gh-Penetration Fire Stops. ice could affect 35 residents in	K 03	72	K372– It is the intent of the facto ensure smoke barrier walls constructed to requirements according to the authority havi jurisdiction (AHJ) to meet set standards.  1 CORRECTIVE ACTIONS TAKEN: a On _05/21/2024 the Maintenance Supervisor/designs sealed the penetrations above ceiling tiles the smoke barrier walls to peach hall and by exit with a one-hour fire rated mate to meet set standards. The Administrator verified the work 5/23/202  2 ALL OTHERS WITH POTENTIAL TO BE AFFECTS and visitors have the potential	are ing  ing  ine gnee the #7 erial con	05/28/2024

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155582	B. W	ING		05/01/	2024
NAME OF D	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					WASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E	WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					be affected but none were. O	n	
		on during a tour of the facility				the	
		ce Director on 05/01/24			Maintenance Supervisor/desig		
	-	and1:45 p.m., above the ceiling			inspected all smoke barrier wa		
		ier walls to Peach Hall and by			and ceilings throughout the fa	-	
	-	enetrations filled with drywall			for penetrations and found no	other	
		sed on records, there was no			negative findings.		
		now the joint compound meets			3 MEASURES TO PREVE	NT	
		ed on an interview at the time of			REOCCURRENCE:		
		intenance Director stated the			a On 05/23/2024t	ne	
	with fire caulk.	not fire rated and will replace it			Administrator in serviced the	, no o	
	with the caulk.				Maintenance Supervisor/design on the requirement that smoke		
	The finding was rev	viewed with the Maintenance			•		
	-	nistrator during the exit			barriers walls and ceilings are constructed to provide at least		
	conference.	instrator during the exit			one hour resistance rating and		
	conference.				must be free from penetration		
	3.1-19(b)				meet set standards.	310	
	3.1 17(0)				b Maintenance		
					Supervisor/designee will inspe	ect	
					all smoke barrier walls and	,,,,	
					ceilings throughout the facility		
					monthly to ensure they remain		
					free of penetrations as a part		
					the facility's Preventive		
					Maintenance Program and		
					document those inspection re-	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig	gnee	
					will review with the Administra	tor	
					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		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155582	B. W	ING		05/01/	/2024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON ST		
WATERS	S OF WAKARUSA	SKILLED NURSING FACILITY, TH	1E	WAKAF	RUSA, IN 46573		
(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 CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					a The inspection results w	/ill	
					a The inspection results which be presented by the Maintena		
					Supervisor/designee to the	11100	
					Administrator monthly and the	غ خ	
					Administrator will present the	•	
					inspection results at the mont	hly	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting	J.	
					Inspection results and system	l	
					components will be reviewed	by	
					the QA/PI Committee with		
					subsequent plans of correctio		
					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		
					05/228/2024		
K 0741	NFPA 101						
SS=E	Smoking Regulati						
Bldg. 01	Smoking Regulati						
		ons shall be adopted and					
		ess than the following					
	provisions:	he prohibited in any room					
	. ,	be prohibited in any room, ment where flammable					
	-	ple gases, or oxygen is					
		d in any other hazardous					
		n area shall be posted with					
		O SMOKING or shall be					
	•	ternational symbol for no					
	smoking.	,					
		occupancies where					
	' '	ited and signs are					
		ed at all major entrances,					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155582	B. WI	NG		05/01/	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573				
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	secondary signs we smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the paresponsible shall be supervision. (5) Ashtrays of not safe design shall be where smoking is (6) Metal contained devices into which shall be readily average smoking is permitted as the same shall be readily average smoking is permitted as the same shall be readily average smoking is permitted as the same shall be readily average smoking policic could affect 15 reside evacuation.  Findings include:  Based on observation Director on 05/01/2 property was eviden butts on the outside records review at 11 smoking is not allowed as the facility is a non-confirmed there was the cigarette butts of the facility of the facili	with language that prohibits be required. atients classified as not be prohibited. Interest of 18.7.4(3) shall not atient is under direct and be provided in all areas permitted. In serious with self-closing cover an ashtrays can be emptied trailable to all areas where	K 0°		K741 – It is the intent of the facility to ensure to enforce nonsmoking policies to meet standards.  1 CORRECTIVE ACTIONS TAKEN: a On 05/11/2024the Administrator/Housekeeping Supervisor/ Maintenance Supervisor removed the cigare butts from the property to meet set standards. The Administrator/Housekeeping Supervisor removed the cigare butts from the property to meet set standards. The Administrator/Housekeeping Supervisor removed the cigare butts from the property to meet set standards. The Administrator and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVERECCURRENCE: a On 05/23/2024 the Administrator/Maintenance/DO will ensure the facility adherest the smoking policy and	set  She ette ett ator 24.  ED: f I to	05/28/2024
	3.1-19(b)		1		procedures to meet set standa	ards.	

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procedures to meet set standards.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155582	B. WING		05/01/2024
NAME OF I	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	ROVIDER OR SUPPLIE	K.	300 N	WASHINGTON ST	
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	IE WAKAI	RUSA, IN 46573	
(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 CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				b Maintenance	
				Supervisor/Administrator/DON	l/Hou
				sekeeping Supervisor/designe	ee
				will conduct weekly inspection	s on
				the property to ensure the	
				Smoking policy and procedure	es
				are being followed. If any iss	ues
				are discovered, they will be	
				addressed and resolved	
				immediately. The Maintenand	
				Supervisor/designee will revie	w
				with the Administrator the	
				inspection results.	
				c The Administrator will	
				monitor adherence to the Smo	oking
				Policy and validate the	
				Preventative Maintenance	
				documentation is in place.	
				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	•
				Quality Assurance/Performan	
				Improvement (QA/PI) meeting	
				Inspection results and system	
				components will be reviewed the QA/PI Committee with	<sup>∪y</sup>
				subsequent plans of correction developed and implemented a	
				deemed necessary to ensure	13
				compliance is maintained.	
				This plan of correction	
				constitutes our credible	
				allegation of compliance wit	h
				all regulatory requirements.	"
1			I	an regulatory requirements.	l

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/01/2024			
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE				STREET ADDRESS, CITY, STATE, ZIP COD  300 N WASHINGTON ST  E WAKARUSA, IN 46573				
(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)	CTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen co containers over 50 under 11.5.2.3.1 ( liquid oxygen con containers under 11.5.2.2 (NFPA 9) Based on observatio failed to ensure 1 o storage/transfer roo indicating that trans 11.5.2.3.1(3) states, indicating that trans smoking in the imm This deficient pract one smoke compart Findings include:  Based on observation Director on 05/01/2 transfilling room co The door to the roo that indicates when occurring. Based on observation, the Ma there was not a sign	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable 0 psi comply with conditions NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) on and interview, the facility f 1 liquid oxygen ms was provided with a sign afterring is occurring. NFPA 99 the area is posted with signs s-filling is occurring and that nediate area is not permitted. ice could affect 20 residents in	K 09		K927– It is the intent of the farto ensure liquid oxygen storage/transfer rooms are provided with a sign indicating transferring is occurring to me set standards.  1 CORRECTIVE ACTIONS TAKEN: a On 05/20/2024	g that set  S  the  talled  cate to  k on	05/28/2024	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/01/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD  300 N WASHINGTON ST  WAKARUSA, IN 46573					
(X4) ID PREFIX TAG		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		This finding was re	viewed with the Maintenance Iministrator during the exit			3 MEASURES TO PREVEREOCCURRENCE: a On 05/23/2024 the Administrator Inserviced the D Maintenance Supervisor/design that we will have the proper signage in place when oxygen transferring is occurring to meset standards. b On 05/23/2024t Administrator/DON/ Maintenance Supervisor/designee Inservice nursing staff on the oxygen position procedures including the proper signage for when the oxygen transferring is occurring meet set standards. c The Administrator will monitor adherence to the Oxygen position oxygen transferring sign is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results we presented by the DON/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 by the QA/PI Committee with subsequent plans of correction developed and implemented at deemed necessary to ensure compliance is maintained. This plan of correction	oON/ gnee  et  he et  cal all  slicy  age  age  ill  hly  ce  by	

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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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/01/2024	
	ROVIDER OR SUPPLIER GOF WAKARUSA S	KILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD  300 N WASHINGTON ST  WAKARUSA, IN 46573			
(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)	TE	(X5) COMPLETION DATE
				constitutes our credible allegation of compliance with all regulatory requirements.  Our date of compliance is 05/28/2024	ı 	

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