STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING -- B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 ALBER ST WABASH, IN 46992

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/24 Facility Number: 000578 Provider Number: 155627 AIM Number: 100267810 At this Emergency Preparedness survey, Waters of Wabash Skilled Nursing Facility West was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 44 and had a census of 24 at the time of this survey. Quality Review completed on 09/03/24	E 0000		
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR	E 0036	**E036** – It is the intent of the facility to ensure to conduct annual training for the Emergency Preparedness Program to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On **September 9, 2024,** the Administrator and DON/Maintenance Supervisor/designee educated all staff on the updated policy and procedures for emergency	09/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kiri Burks	Administrator	09/13/2024

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	483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 08/29/24 at 1:31 p.m., the annual EEP training was completed but documentation to show if staff could demonstrate knowledge of the EPP was not available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was conducted within the last year but did not have documentation to show if staff could demonstrate knowledge of the EPP. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.		preparedness training to ensure all staff can demonstrate knowledge of the EPP to meet set standards. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On **August 30, 2024,** the Administrator educated DON/Maintenance Supervisor/designee on the requirement to review and update the policy and procedures for emergency training of staff annually to meet set standards. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to review and update the policy and procedures for emergency training of staff annually in the emergency preparedness plan to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and	

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			DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QAPI) meeting. Results and system components will be reviewed by the QAPI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 25, 2024**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/24 Facility Number: 000578 Provider Number: 155627 AIM Number: 100267810	K 0000		

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	155627	A. BUILDING 01 B. WING	08/29/2024

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	At this Life Safety Code survey, Waters of Wabash Skilled Nursing Facility West was found not 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. This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 44 and had a census of 24 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including activity storage and maintenance supplies that were not sprinklered. Quality Review completed on 09/03/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure: 1) The corridor door to 1 of 1 storage rooms which was a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame.	K 0321	**K321**– It is the intent of the facility to ensure corridor door to storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet are provided with a self-closing device which would cause the door to automatically close and latch into the door frame and to ensure hazardous rooms that contain fuel	09/25/2024

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	2) 1 of 3 hazardous rooms that contained fuel fired equipment was separated from other spaces by smoke resistant partitions. These deficient practices affects 15 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 08/29/24 at 2:31 p.m. and 2:57 p.m., 1) Storage room 21, a hazardous storage room that was greater than 50 square feet, was equipped with a self-closing device but did not latch into the frame when the air conditioner (AC) was running. Based on interview at the time of observation, the Maintenance Director agreed the room was used as storage, was larger than 50 square feet, and stated when the AC is running it creates negative pressure that keeps the door from latching, but the door did latch when the AC is not running. 2) The water softener/mechanical room with a fuel-fired furnace, had a 2 foot by 2 foot drywall patch over a hole but the edges of the patch were not sealed and had gaps. Based on interview at the time of the observation, the Maintenance Director agreed the edges of the patch were not sealed and had gaps in a mechanical room which contained fuel-fired equipment. These findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		fired equipment are separated from other spaces by smoke resistant partitions to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On **September 3, 2024,** the Maintenance Supervisor/designee made repairs to the hazardous storage room door to ensure the door always closes and latches into the frame to meet set standards. The Administrator verified the work on **September 6, 2024** b On **September 3, 2024,** the Maintenance Supervisor/designee repaired the drywall with gaps with one a one-hour fire resistant rated material in the water softener/mechanical room to meet set standards. The Administrator verified the work on **September 6, 2024** **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On **August 30, 2024,** the Administrator educated the Maintenance Supervisor/designee and all staff on the requirement to ensure hazardous areas are equipped with a self-closing door and ensure there are no penetrations in the walls to prevent the door from closing to meet set	

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			standards. b Maintenance Supervisor/designee will ensure hazardous areas are equipped with a self-closing door and ensure there are no penetrations in the walls as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QAPI) meeting. Inspection results and system components will be reviewed by the QAPI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring, and that smoking is the immediate area is not permitted. This deficient practice could affect 12 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 08/29/24 at 2:20 p.m., the oxygen transfilling room contained liquid oxygen tanks. The door to the room was not provided with sign that indicates when transfilling of oxygen is occurring. Based on interview at the time of observation, the Maintenance Director stated there was not a sign that indicates when transfilling of oxygen is occurring. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0927	**This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 25, 2024** **K927**– It is the intent of the facility to ensure liquid oxygen storage/ transfer rooms are provided with a sign indicating that transferring is occurring to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On **August 30, 2024,** the Maintenance Supervisor installed a sign indicating when oxygen transfilling is occurring on the door to the oxygen transfilling room to meet set standards. The Administrator verified the work on **September 6, 2024** 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On **August 30, 2024,** the Administrator educated the Maintenance Supervisor/designee to ensure the oxygen transfilling room has a sign on the door that indicated when transfilling is	09/25/2024

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			occurring to meet set standards. 1.Maintenance Supervisor/designee will ensure the oxygen transfilling room has a sign on the door that indicated when transfilling is occurring as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the DON/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QAPI) meeting. Inspection results and system components will be reviewed by the QAPI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 25, 2024**	

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