PRINTED: 09/20/2024
FORM APPROVED
OMB NO. 0938 039

CENTERS FO	R MEDICARE & MEDIC			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION (	(X3) DATE SURVEY COMPLETED		
		155627	B. WING		08/29/2024	
	PROVIDER OR SUPPLIEF	LLED NURSING FACILITY WES	1720 A	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI		
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
L 0000						
Bldg	conducted by the In accordance with 42		E 0000			
	of Wabash Skilled found in substantial compliance with Er Requirements for M Participating Provid 483.73. The facility census of 24 at the	200578 255627 267810  Preparedness survey, Waters Nursing Facility West was mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR r has a capacity of 44 and had a				
E 0036 SS=C Bldg	EP Training and T Based on record rev failed to conduct an Emergency Prepare facility must do all training in emergen procedures to all ne individuals providing and volunteers, con roles; (ii) Provide e training at least and documentation of a training; (iv) Demo	4(d), 418.113(d), 441.1 Testing  View and interview, the facility inual training for the dness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and w and existing staff, ing services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain all emergency preparedness instrate staff knowledge of the res in accordance with 42 CFR	E 0036	E036 – It is the intent of the facto ensure to conduct annual training for the Emergency Preparedness Program to mee set standards.  1 CORRECTIVE ACTIONS TAKEN:  a On September 9, 2024, the Administrator and DON/Maintenance Supervisor/designee educated staff on the updated policy and procedures for emergency	t all	

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

(X6) DATE

TITLE

Kiri Burks Administrator 09/13/2024

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 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: T76C21 Facility ID: 000578 If continuation sheet Page 1 of 9

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155627		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/29/2024			ETED		
	PROVIDER OR SUPPLIER	LED NURSING FACILITY WEST		1720 AL	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
WATERS  (X4) ID  PREFIX  TAG	SUMMARY SEARCH DEFICIEN REGULATORY OR 483.73(d) (1). This all residents in the form of the findings include:  Based on records reand the Maintenance p.m., the annual EE documentation to showledge of the E review. Based on arrecords review, the Administrator stated conducted within the documentation to showledge of the E. The finding was revenue.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION deficient practice could affect acility.  view with the Administrator e Director on 08/29/24 at 1:31 P training was completed but now if staff could demonstrate PP was not available for a interview at the time of Maintenance Director and the d the EPP training was e last year but did not have now if staff could demonstrate				re all dge rds.  ED: and e	(X5) COMPLETION DATE
					b DON/Maintenance Supervisor/designee will work the Administrator to ensure to review and update the policy a procedures for emergency tra of staff annually in the emerge preparedness plan to meet se standards. If any issues are discovered, they will be addre and resolved immediately. c The Administrator will mor adherence to the Emergency Preparedness Policy Manual a validate the documentation is place.  4 MONITORING CORRECT ACTION: a At least annually to ensure	with and ining ency t ssed aitor and in	

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2024	
	PROVIDER OR SUPPLIEI S OF WABASH SKI	LLED NURSING FACILITY WEST	1720 A	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992	
(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)	(X5) COMPLETION DATE
				DON/Maintenance Supervisor/designee will revie Emergency Preparedness Pol Manual and conduct required exercises and make changes necessary to meet set standar Those reviews will be docume as appropriate. The Administra will present the training results the Quality Assurance/ Performance Improvement (Q meeting. Results and system components will be reviewed by the QAPI 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 September 25, 2024	as rds. ented ator s at  API) by
K 0000					
Bldg. 01	Licensure Survey v	00578 155627	K 0000		

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

Event ID:

T76C21

Facility ID: 000578

If continuation sheet

Page 3 of 9

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155627	B. WING 08/29/2024				
				CTD FFT A	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED		LLED AULIDOING EAGULITY MEGT			LBER ST		
WATERS	OF WABASH SKII	LLED NURSING FACILITY WEST		WABAS	SH, IN 46992		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	At this Life Safety	Code survey, Waters of					
	Wabash Skilled Nu	rsing Facility West was found					
	not in compliance v	vith Requirements for					
	Participation in Me	dicare/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),					
	· ·	g Health Care Occupancies and					
	410 IAC 16.2.						
	This one story facil	ity was determined to be of					
	Type III (200) cons	truction and was fully					
	sprinklered. The fa	cility has a fire alarm system					
	with smoke detection	on in the corridors, areas open					
	to the corridors and	battery operated smoke					
	detectors in the resi	dent rooms. The facility has a					
	capacity of 44 and l	had a census of 24 at the time					
	of this survey.						
		residents have customary					
	_	ered. The facility had two					
	_	viding facility services					
		torage and maintenance					
	supplies that were r	not sprinklered.					
	Quality Review cor	mpleted on 09/03/24					
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01							
		on and interview, the facility	K 0.	321	<b>K321</b> – It is the intent of the fac	•	09/25/2024
	failed to ensure:				to ensure corridor door to stor	•	
	1) 771	. 1 61			rooms which is a hazardous a		
		or to 1 of 1 storage rooms which			containing combustible storag		
		ea containing combustible			and greater than 50 square fe		
		than 50 square feet was			are provided with a self-closing	•	
	_	f-closing device which would			device which would cause the		
		utomatically close and latch			to automatically close and late		
	into the door frame.				into the door frame and to ens		
			1		hazardous rooms that contain	tuel	I

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

Event ID:

T76C21

Facility ID: 000578

If continuation sheet

Page 4 of 9

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

CENTERS	FOR MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PL	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	01	COMPL	LETED	
		155627	B. WING		08/29	/2024	
			CED FIE	TARRESS OF A STATE OF SOR			
NAME	OF PROVIDER OR SUPPLIEF	₹		T ADDRESS, CITY, STATE, ZIP COD			
\A/A T				ALBER ST			
WAIL	EKS OF MARASH SKI	LLED NURSING FACILITY WEST	WAB	ASH, IN 46992			
(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 APPROPRI DEFICIENCY)	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	IATE	DATE	
	2) 1 of 3 hazardous	rooms that contained fuel fired		fired equipment are separate	d from		
	· · ·	arated from other spaces by		other spaces by smoke resis			
	smoke resistant par			partitions to meet set standar			
	1			1 CORRECTIVE ACTIONS			
	These deficient prac	ctices affects 15 residents in		TAKEN:			
	two smoke compart			a On <u>September 3, 2024,</u> t	he		
	two smoke compart	inones.		Maintenance Supervisor/desi			
	Findings include:			made repairs to the hazardou	-		
	i manigs merade.			storage room door to ensure			
	Based on observation	ons with the Maintenance		door always closes and latch			
		24 at 2:31 p.m. and 2:57 p.m.,		into the frame to meet set	C3		
	Director on 08/23/2	.4 at 2.31 p.m. and 2.37 p.m.,		standards. The Administrator			
	1) Storage room 21	I, a hazardous storage room					
	, ,	n 50 square feet, was		verified the work on Septemb	<u>jer 6,</u>		
	_	-		2024	L .		
		f-closing device but did not		b On <u>September 3, 2024,</u> t			
		when the air conditioner (AC)		Maintenance Supervisor/desi			
	_	on interview at the time of		repaired the drywall with gap			
		nintenance Director agreed the		one a one-hour fire resistant	rated		
		torage, was larger than 50		material in the water			
	-	ted when the AC is running it		softener/mechanical room to			
		essure that keeps the door		set standards. The Administr			
		he door did latch when the AC		verified the work on Septemb	<u>oer 6,</u>		
	is not running.			<u>2024</u>			
	A						
	· · ·	er/mechanical room with a		2 ALL OTHERS WITH			
		nad a 2 foot by 2 foot drywall	1	POTENTIAL TO BE AFFECT	ED:		
	-	ut the edges of the patch were		a All residents and all staff			
		gaps. Based on interview at		visitors have the potential to	be		
		ervation, the Maintenance		affected but none were.			
		edges of the patch were not		3 MEASURES TO PREVEN	١T		
		sealed and had gaps in a mechanical room which		REOCCURRENCE:			
	contained fuel-fired	l equipment.		a On <u>August 30, 2024,</u> the			
				Administrator educated the			
	_	e reviewed with the		Maintenance Supervisor/desi	ignee		
	Maintenance Direct	tor and the Administrator		and all staff on the requireme	ent to		
	during the exit conf	ference.		ensure hazardous areas are			
				equipped with a self-closing of	door		
	3.1-19(b)			and ensure there are no			

penetrations in the walls to prevent the door from closing to meet set

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

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	ROVIDER OR SUPPLIEI OF WABASH SKI	LLED NURSING FACILITY WEST	1720 A	ADDRESS, CITY, STATE, ZIP COD LBER ST SH, IN 46992		
(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)	(X5) COMPLETION DATE	
				standards. b Maintenance Supervisor/designee will ensure hazardous areas are equippe with a self-closing door and end there are no penetrations in the walls as a part of the facility's monthly Preventive Maintenant Program and document those inspection results as appropril from the addressed and resolve immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will more adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation in place.  4 MONITORING CORRECT ACTION: a The inspection results will presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QAPI) meeting Inspection results and system components will be reviewed the QAPI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure	are d nsure ne nce e ate. they ed ce ew  nitor e  s in  IVE  be e  hly ce . by n	
				compliance is maintained.		

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

Event ID:

T76C21

Facility ID: 000578

If continuation sheet

Page 6 of 9

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155627		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  08/29/2024					
	NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST			STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST				
(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			
				This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.  Our date of compliance is  September 25, 2024				
K 0927 SS=E Bldg. 01	Based on observation failed to ensure 1 of storage/transfer roo indicating that trans 11.5.2.3.1(3) states, indicating that trans smoking is the imm. This deficient pract one smoke compart. Findings include:  Based on observation. Director on 08/29/2 transfilling room control that indicates when occurring. Based or observation, the Mathere was not a sign transfilling of oxyg.	ms was provided with a sign sferring is occurring. NFPA 99 the area is posted with signs s-filling is occurring, and that sediate area is not permitted. ice could affect 12 residents in ment.  Ons with the Maintenance 4 at 2:20 p.m., the oxygen ontained liquid oxygen tanks. In was not provided with sign transfilling of oxygen is a interview at the time of sintenance Director stated at that indicates when	K 0927	K927– It is the intent of the facto ensure liquid oxygen storage transfer rooms are provided with sign indicating that transferring occurring to meet set standard 1 CORRECTIVE ACTIONS TAKEN:  a On August 30, 2024, the Maintenance Supervisor instates a sign indicating when oxygen transfilling is occurring on the to the oxygen transfilling room meet set standards. The Administrator verified the work September 6, 2024  2 ALL OTHERS WITH POTENTAL TO BE AFFECTE A All residents and all staff a visitors have the potential to be affected but none were.  3 MEASURES TO PREVENT REOCCURRENCE:  a On August 30, 2024, the	ge/ gith a g is g is ds.  Illed n door n to c on			
	3.1-19(b)			Administrator educated the Maintenance Supervisor/design to ensure the oxygen transfilling room has a sign on the door t	ng			

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

Event ID:

T76C21

Facility ID: 000578

3

indicated when transfilling is

If continuation sheet Pag

Page 7 of 9

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED	
		155627	B. WING 08/29/				
100021			D. 111	_		00/20/	2021
NAME OF F	PROVIDER OR SUPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	KO VIDEK OK SOI I EIEI			1720 Al	LBER ST		
WATERS	OF WABASH SKI	LLED NURSING FACILITY WEST		WABAS	SH, IN 46992		
(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	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					occurring to meet set standard	ds.	
					1.Maintenance		
					Supervisor/designee will ensu	re	
					the oxygen transfilling room ha		
					sign on the door that indicated		
					when transfilling is occurring a		
					part of the facility's Preventive		
					Maintenance Program and		
					document those inspection res	sults	
					as appropriate. If any issues a		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra		
					the inspection results.		
					and moposition results.		
					4 MONITORING CORRECT	IVE	
					ACTION:		
					a The inspection results will	be	
					presented by the DON/design		
					the Administrator monthly and		
					Administrator will present the		
					inspection results at the month	nlv	
					Quality Assurance/Performand	-	
					Improvement (QAPI) meeting.		
					Inspection results and system		
					components will be reviewed I		
					the QAPI Committee with	- )	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					Compilation is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance witl	h	
					all regulatory requirements.		
					Our date of compliance is		
					September 25, 2024		

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

Event ID:

T76C21

Facility ID: 000578

If continuation sheet

Page 8 of 9

PRINTED: 09/20/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155627	B. WING			08/29/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF WABASH SKILLED NURSING FACILITY WEST				STREET ADDRESS, CITY, STATE, ZIP COD 1720 ALBER ST WABASH, IN 46992				
(X4) ID	SUMMARY S	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 APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE AP			DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T76C21 Facility ID: 000578 If continuation sheet Page 9 of 9