STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER S OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W E	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST IBIA CITY, IN 46725	
(X4) ID PREFIX TAG E 0000	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 10/24/23  Facility Number: 000071 Provider Number: 155150 AIM Number: 100273140  At this Emergency Preparedness survey, Waters of Columbia City Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 84 and had a census of 36 at the time of this survey.  Quality Review completed on 10/31/23	E 0000		
E 0039 SS=F Bldg	The requirements of 42 CFR, Subpart 483.73 are  Not Met as evidenced by:  403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)  EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)  (2), §491.12(d)(2), §494.62(d)(2).  *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,	IATURE	TITLE	(X6) DATE

Laurie Barnes **Executive Director** 11/09/2023

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.

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i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155150	B. W	ING		10/24	/2023
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
			,		ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILIT	<i>'</i>	COLUM	IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	_	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [facility] must conduct						
		he emergency plan					
		ility] must do all of the					
	following:						
	(i) Participate in a full scale evergice that is						
	(i) Participate in a full-scale exercise that is community-based every 2 years; or						
		nunity-based exercise is					
	' '	nduct a facility-based					
	functional exercise every 2 years; or  (B) If the [facility] experiences an actual						
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the [facility]					
		igaging in its next required					
		or individual, facility-based					
		e following the onset of the					
	actual event.	ditional avancia a st la set					
	' '	ditional exercise at least posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
		scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise	e; or					
	(B) A mock disast						
		ercise or workshop that is					
	1	and includes a group					
	discussion using a						
	set of problem sta	emergency scenario, and a					
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed					

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Event ID:

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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	ETED
		155150	B. W	ING		10/24/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ELLSWORTH ST		
WATERS	OF COLUMBIA C	ITY SKILLED NURSING FACILITY			IBIA CITY, IN 46725		
(X4) ID	CIMMADV	STATEMENT OF DEFICIENCIE	1	ID		·	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
IAG	REGULATORT OF	CESC IDENTIF I ING INFORMATION	1	IAG			DATE
	*[For Hospices at	418 113(d)·1					
	-	spices that provide care in					
		e. The hospice must					
	-	s to test the emergency					
		ally. The hospice must do					
	the following:	,					
		a full-scale exercise that is					
	community based						
		nunity based exercise is not					
	accessible, condu	ct an individual facility					
	based functional e	exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
	exempt from enga	nging in its next required full					
	scale community-	based exercise or individual					
	•	tional exercise following the					
	onset of the emer	<del>-</del>					
	, ,	dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted, that may					
		limited to the following:					
	, ,	scale exercise that is					
		or a facility based					
	functional exercise						
	(B) A mock disas						
	, ,	ercise or workshop that is					
	-	and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta	pared questions designed					
	to challenge an er						
	to challenge all el	norgonoy pian.					
	(3) Testing for hos	spices that provide inpatient					
	` '	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155150	B. W	ING		10/24	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILITY	<u> </u>		IBIA CITY, IN 46725		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. ,	an annual full-scale exercise					
	that is community						
	1 ' '	nunity-based exercise is not					
		uct an annual individual					
	-	ctional exercise; or					
	. ,	experiences a natural or					
		ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event	dditional annual exercise					
	` '	but is not limited to the					
	following:	but is not limited to the					
		-scale exercise that is					
	1 ' '	or a facility based					
	functional exercis						
	(B) A mock disas						
	1 ' '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
	_	ario, and a set of problem					
		ted messages, or prepared					
		ed to challenge an					
	emergency plan.	•					
		nospice's response to and					
	, ,	ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
		-					
	-	141.184(d), Hospitals at					
	§482.15(d), CAH	- , , -					
	. ,	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	_					
		an annual full-scale exercise					
	that is community	-based; or					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155150	B. Wl	NG		10/24/	/2023
NAME OF T	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	NOVIDER OR SUPPLIER			640 W E	ELLSWORTH ST		
WATERS	OF COLUMBIA C	ITY SKILLED NURSING FACILITY		COLUM	MBIA CITY, IN 46725		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)		TE	COMPLETION	
IAU		R LSC IDENTIFYING INFORMATION nunity-based exercise is not	$\vdash$	IAU			DATE
	, ,	ct an annual individual,					
		ctional exercise; or					
	•	Hospital, CAH] experiences					
	. , -	or man-made emergency					
		ation of the emergency					
		is exempt from engaging in					
		ull-scale community based					
	· ·	ty-based functional exercise					
		et of the emergency event.					
	-	an [additional] annual					
	` '	at may include, but is not					
	limited to the follo	•					
		scale exercise that is					
	community-based						
	facility-based fund						
	•	ock disaster drill; or					
	` '	exercise or workshop that					
	. ,	or and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze tl	he [facility's] response to					
	and maintain docเ	umentation of all drills,					
	tabletop exercises	s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	60.84(d):]					
		PACE organization must					
	. , -	to test the emergency					
	plan at least annu						
	organization must	-					
	-	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	` '	ict an annual individual,					
	facility based fund		1				1

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Facility ID: 000071

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	ETED
		155150	B. Wl	NG		10/24	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIER	8			ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILITY	, 	COLUMBIA CITY, IN 46725			
(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 APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	is exempt from engaging in its next required						
		nity based or individual,					
		ctional exercise following the					
	onset of the emer	•					
		n additional exercise every					
		he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to	_					
		scale exercise that is					
	-	or individual, a facility					
	based functional e						
	(B) A mock disas						
		ercise or workshop that is					
	T	and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
	to challenge an er	pared questions designed					
		PACE's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
		gone, plan, ao noodoa.					
	*[For LTC Facilitie	es at \$483.73(d):1					
	1 -	ity] must conduct exercises					
		ency plan at least twice per					
	_	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	=					
	-	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ict an annual individual,					
	facility-based fund						
	1 -	ility] facility experiences an					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023			
		ROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY		640 W E	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST IBIA CITY, IN 46725		
	(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
		requires activation LTC facility is exercises to test the twice per year. The following:  (a) A second full-community-based based functional exercises to test the twice per year. The following:  (b) A mock disass (C) A tabletop exercises to test the twice per year. The following:  (c) A tabletop exercises to test the twice per year. The following:  (d) Testing. The IC exercises to test the twice per year. The following:  (e) Participate in an activation of the exercises for the exercises for the exercise of the community-(A) When a community-(B) If the ICF/IID exercises for the exe	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed.  483.475(d)]: CF/IID must conduct me emergency plan at least e ICF/IID must do the					

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Facility ID: 000071

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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	ETED
		155150	B. W	NG		10/24/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ELLSWORTH ST		
WATERS	S OF COLUMBIA C	ITY SKILLED NURSING FACILITY			IBIA CITY, IN 46725		
		THE ORIELES HOROTOTALITY		002011			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROPERTY OF THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		nity-based or individual,					
	1	ctional exercise following the					
	onset of the emer						
	1 ' '	ditional annual exercise					
	· ·	but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
	1	tional exercise; or					
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
	discussion, using	and includes a group					
		emergency scenario, and a					
	set of problem sta	9					
	1	pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		gone, plan, ao nobaban					
	*[For HHAs at §48	34.1021					
	_	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
	_	full-scale exercise that is					
	community-based						
	(A) When a c	ommunity-based exercise					
	is not accessible,	conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from enga	aging in its next required					
	full-scale commun	nity-based or individual,					
	facility based fund	tional exercise following the					
	onset of the emer	gency event.					

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155150	B. W	- DNI		10/24	2023
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
\\\\\ TED		ITV OVILLED NILIDOINO EXCULT	,		ELLSWORTH ST		
	OF COLUMBIA C	ITY SKILLED NURSING FACILITY		COLUN	IBIA CITY, IN 46725		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ditional exercise every 2		TAG	Dia tellite 17		DATE
	, ,	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is conducted, that may						
	include, but is not limited to the following:						
	(A) A second full-scale exercise that is						
	community-based						
		tional exercise; or					
	, ,	isaster drill; or o exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
	_	emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er	- · ·					
		HA's response to and					
		ntation of all drills, tabletop nergency events, and revise					
		ency plan, as needed.					
	and this to omorgo	plan, as nesasa.					
	*[For OPOs at §48	36.360]					
	` ' ' '	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	<del>-</del>					
		er-based, tabletop exercise ast annually. A tabletop					
		a facilitator and includes a					
	_	using a narrated, clinically					
		cy scenario, and a set of					
	_	its, directed messages, or					
	prepared questior	ns designed to challenge an					
	emergency plan. I	f the OPO experiences an					
		nan-made emergency that					
		of the emergency plan, the					
	· ·	om engaging in its next					
		xercise following the onset					
	of the emergency	event. PO's response to and					
	I ' '	ntation of all tableton					

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155150		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2023		
	PROVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the [RNHCI's and needed.  *[ RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCI must do the (i) Conduct a paper at least annually. It group discussion I narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and emithe RNHCI's emer Based on record reversible of the conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community accessible, conduct facility-based function. If the LTC facilit or man-made emerge of the emergency please from engaging its not community-based of full-scale functional the onset of the actu (ii) Conduct an additional conduct and conduct an additional conduct and conduct	e RNHCI must conduct the emergency plan. The the following: the based, tabletop exercise that tabletop exercise is a ted by a facilitator, using a the arrelevant emergency that of problem statements, the special exercise to and that the statements and revise the gency plan. The statements and revise the gency events, and revise the gency plan, as needed. The statements are the test the emergency the statements and revise the statements and the statements t	E 0039	- It is the intent of the facility ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using emergency procedures to me set standards.  1 CORRECTIVE ACTION TAKEN:  a OnSeptember 25,20 the Administrator and the DO Maintenance Supervisor/design conducted a second communifacility-based exercise and documented the results in the Safety Binder to meet set standards.  2 ALL OTHERS WITH POTENTIAL TO BE AFFECT a All residents and all staff and visitors have the potentia	o ast  g the et  S  D23_ N/ gnee ity or  Life  ED:

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r ′		ONSTRUCTION	(X3) DATE SUI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<del></del>	COMPLET	
		155150	B. WI	NG		10/24/20	23
NAME OF P	DOMNED OF CURRITER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		640 W	ELLSWORTH ST		
WATERS	OF COLUMBIA CI	TY SKILLED NURSING FACILITY		COLUM	MBIA CITY, IN 46725		
(X4) ID	SUMMARY	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 DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	•	r an individual, facility-based			be affected but none were.		
	functional exercise.				3 MEASURES TO PREVE	NT	
	b. A mock disaster				REOCCURRENCE:		
	_	se or workshop that is led by a			a OnSeptember 25		
		des a group discussion, using			2023 the Administrato		
		y-relevant emergency scenario,			inserviced the DON/ Maintena	nce	
	and a set of problem statements, directed messages, or prepared questions designed to				Supervisor/designee on the		
					requirement that a community		
	challenge an emergency plan.				facility-based exercise must be		
(iii) Analyze the LTC facility's response to and				conducted at least twice per y and documentation retained to			
maintain documentation of all drills, tabletop				meet set standards.	)		
	exercises, and emergency events, and revise the				b DON/Maintenance		
	LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This				Supervisor/designee will work	with	
		ould affect all occupants.			the Administrator to ensure a	WILLI	
	deficient practice co	ould affect all occupants.			community or facility-based is		
	Findings include:				conducted at least twice per y	oor	
	Findings include.				and documentation retained to		
	Rosed on record res	view and interview with the			meet set standards. If any	,	
		for (MD) on 10/24/23 at 02:00			issues are discovered, they w	ill bo	
		tion of a second community or			addressed and resolved	ii be	
	-	il exercise was available, but			immediately.		
	•	ne annual exercise on 09/14/23			c The Administrator will		
		view. Based on interview at the			monitor adherence to the		
		ew, the MD stated the facility			Emergency Preparedness Pol	icv	
		n a full-scale exercise that is			Manual and validate the	.~,	
		out completed one facility			documentation is in place.		
	•	in the last 12 months. The			4 MONITORING		
		I to do a second facility based			CORRECTIVE ACTION:		
	exercise on 10/25/2	-			a At least annually to ensu	<sub>ire</sub>	
	- 141				compliance, the Administrator		
	This finding was re	viewed with the Administrator			DON/Maintenance		
	and MD at the exit				Supervisor/designee will revie	w the	
					Emergency Preparedness Pol		
					Manual and conduct required	´	
					exercises and make changes	as	
					necessary to meet set standar		
					Those reviews will be docume		
					as appropriate. The Administra		
					will present the training results		

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	LAN OF CORRECTION IDENTIFICATION NUMBER  155150		A. BUILDING  B. WING	onstruction 	COMPLETED 10/24/2023
	OVIDER OR SUPPLIER	TY SKILLED NURSING FACILITY	640 W I	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	the Quality Assurance/ Performance Improvement (Quality Results and system components will be reviewed to 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 or before November 10, 2023	A/PI)  by  n as
	Survey Date: 10/24 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C Columbia City Skill not in compliance w Participation in Med Subpart 483.90(a), I 2012 edition of the I Association (NFPA)	00071 55150			

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155150	B. WING			10/24/	2023
				TDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ELLSWORTH ST		
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY					IBIA CITY, IN 46725		
ı	00201111111111111	THE CHILLES HOROTOTICATE		702011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	410 IAC 16.2.						
		ity was determined to be of					
		ruction and was fully					
	-	cility has a fire alarm system					
		on in the corridors, areas open					
		battery powered smoke					
	detectors in the resident sleeping rooms. The						
	facility has a capacity of 84 and had a census of						
	36 at the time of this survey.						
	All areas where the residents have customary						
	access were sprinklered. All areas providing facility services were sprinklered.						
	facility services wer	re sprinkiered.					
	Quality Review con	npleted on 10/31/23					
K 0223	NFPA 101						
SS=E	Doors with Self-Cl	osina Devices					
Bldg. 01	Doors with Self-Closing Devices						
3 -	Doors in an exit passageway, stairway						
	enclosure, or horizontal exit, smoke barrier,						
	or hazardous area enclosure are self-closing						
	and kept in the closed position, unless held						
	open by a release device complying with						
		matically closes all such					
	doors throughout t	the smoke compartment or					
	entire facility upon	· ·					
		ıl fire alarm system; and					
		ectors designed to detect					
	smoke passing thr	rough the opening or a					
	required smoke de	etection system; and					
	* Automatic sprinkler system, if installed; and						
	* Loss of power.						
	18.2.2.2.7, 18.2.2.	2.8, 19.2.2.2.7, 19.2.2.2.8					
	Based on observation and interview, the facility			3	– It is the intent of the facility to	o	11/10/2023
		f 1 storage rooms with large			ensure storage rooms with larg		
		tible storage and greater than			amounts of combustible storage	~	
	50 square feet was p	protected as a hazardous area.			and greater than 50 square fee	_	
	This deficient practi	ice could affect 5 residents in			are protected as hazardous ar		

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
		155150	B. WING		10/24/2023	
			CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST		
\M\ATEDS	S OF COLLIMBIA C	ITY SKILLED NURSING FACILITY		MBIA CITY, IN 46725		
WATERS	OF COLUMBIA C	THE SKILLED NORSING FACILITY	COLUN	1BIA CITT, IN 40725		
(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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	the area.			to meet set standards.		
				1 CORRECTIVE ACTIONS	3	
	Findings include:			TAKEN:		
				a OnOctober 24,		
	Based on observation	on during a tour of the facility		2023 the Maintenance		
	with the Maintenan	ce Director (MD) on 10/24/23		Supervisor/designee removed	l the	
	_	herapy storage room contained		box that was holding door ope	n in	
		applies and was greater than 50		the Therapy Storage Room to	i .	
		this a hazardous area. The		meet set standards. The		
	-	ot protected as a hazardous		Administrator verified the worl	< on	
	area because the door to the room was held open.  Based on interview at the time of observation, the  MD agreed the storage room contained large			_October 24, 2023 .		
				2 ALL OTHERS WITH		
				POTENTIAL TO BE AFFECTI	ED:	
		ible storage, was larger than 50		a All residents and all staf	f	
	square feet, and the door to the room was held			and visitors have the potential	to	
	open by a box.			be affected but none were. O	n	
				November 7, 20231	the	
	_	viewed with the Administrator		Maintenance Supervisor/desig		
	and the MD during	the exit conference.		inspected all doors throughou		
				facility and found no other neg	jative	
	3.1-19(b)			findings.		
				3 MEASURES TO PREVE	.NT	
				REOCCURRENCE:		
				a The Administrator will		
				inservice Maintenance Superv	/isor	
				& all staff including Physical		
				Therapy Staff on the requirem		
				to keep doors with self-closing		
				devices in closed position and		
				ensure there are no obstruction		
				to closing to meet set standar	ds.	
			1	b Maintenance		
				Supervisor/designee will inspe		
				all doors throughout the facilit	У	
				monthly to ensure they have		
				self-closing devices in closed		
				position and have no obstruct		
				to closing as a part of the facil	•	
			Preventive Maintenance Prog	ram		

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and document those inspection

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPL	COMPLETED	
155150					/2023		
					_		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					ELLSWORTH ST		
WATERS	S OF COLUMBIA C	CITY SKILLED NURSING FACILITY		COLUM	IBIA CITY, IN 46725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
					results as appropriate. If any		
					issues are discovered, they w		
					addressed and resolved		
					immediately. The Maintenand	e	
					Supervisor/designee will revie		
					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 w	ill	
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	าly	
					Quality Assurance/Performan	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed l	by	
					the QA/PI Committee with		
					subsequent plans of correction	n	
					developed and implemented a	ıs	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is o		
					or before November 10, 2023	3.	
K 0524	NEDA 404						
K 0531	NFPA 101						
SS=E	Elevators		l		1		1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER					COMPLETED	
		155150	B. WI	NG		10/24/	2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DROWING BLANCE CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	rc	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
Bldg. 01	Elevators are insp specified in ASME Elevators and Esc Service is operate record.  Existing elevators A17.3, Safety Cod and Escalators. Al a travel distance obelow the level that emergency persor purposes, conform Requirements of A (Includes firefighter recall and smoke of firefighter's service key operation, madetectors, and elevatectors.)  19.5.3, 9.4.2, 9.4.3 Based on observation failed to ensure 1 of equipped with a self required. ASME 17 and escalators required doors to be self-closideficient practice con in the corridor by the Findings include:  Based on observation Maintenance Direct the door to the elevate equipped with a self self-closing device of self-closing devices and self-	n with Firefighter's Service ASME/ANSI A17.3.  er's service Phase I key detector automatic recall, e Phase II emergency in-car chine room smoke evator lobby smoke  3 on and interview, the facility 6 I elevator machine room 6-closing door functioned as 6.1-Safety Code for elevators res elevator machine room sing and self latching. This buld affect staff and residents	K 0:	531	- It is the intent of the facility to ensure elevator machine room equipped with a self-closing do functioned as required to meet standards.  1 CORRECTIVE ACTIONS TAKEN:  a OnNovember 2, 202 the Maintenance Supervisor repaired the self-closing device the elevator machine room to ensure it self closes and latche into the door frame to meet se standards.  2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE a All residents and all staff	is por taset as a set	11/10/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155150		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIE S OF COLUMBIA C	R ITY SKILLED NURSING FACILIT	640 W	ADDRESS, CITY, STATE, ZIP COD ELLSWORTH ST MBIA CITY, IN 46725	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	interview at the time of observation, the Maintenance Director agreed the self-closing device on the door was not functioning properly as it did not allow the door to latch.  The finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b)			and visitors have the potential be affected but none were.  3 MEASURES TO PREVERECCURRENCE:  a OnNovember 9, 202 the Administrator inserviced of Maintenance Supervisor/desson the requirement to ensure self-closing devices on the elemachine room are working properly and the door self closet and latches into the frame to set standards.  b Maintenance Supervisor/designee will ensure the self-closure on the elevate machine room door is workin properly and the door self closet and latches into the frame as part of the facility's monthly Preventive Maintenance Programd document those inspection results as appropriate. If an issues are discovered, they waddressed and resolved	DATE  DATE  DATE  DATE  DATE  DATE  DATE  DATE
				immediately. The Maintenan Supervisor/designee will reviwith 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 when the presented by the Maintenance of the Supervisor/designee to the	ew

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155150	B. WI	NG		10/24/	2023
NAME OF PROVIDER OR SUPPLIER WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DROVIDER'S BLANGE 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'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
K 0712 SS=F	NFPA 101 Fire Drills				Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is or before November 10, 2023.	nly ce oy n s	
Bldg. 01	alarm signal and signal and signal and unexpected tile conditions, at leas. The staff is familia aware that drills all routine. Where dried 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1 Based on record reviailed to conduct fir quarters. LSC 19.7.	ay be used instead of	K 0°	712	— It is the intent of the facility to ensure to conduct fire drills on each shift for all four quarters meet set standards.		11/10/2023

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155150	B. WING 10/24/2023			/2023	
NAME OF PROVIDER OR SUPPLIER WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP COD 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725				
(X4) ID	SUMMARY 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 APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	• •	nurses, interns, maintenance			1 CORRECTIVE ACTIONS	3	
		inistrative staff) with the			TAKEN:		
		ncy action required under			a On October 24, 2023 the	9	
		This deficient practice affects			Administrator inserviced the		
	all staff and residen	ts.			Maintenance Supervisor/desig	•	
				on the requirement that fire drills			
	Findings include:			must be conducted at unexpecte			
				times under varying conditions at			
		view with the Maintenance		least quarterly on each shift and			
		0/24/23 at 11:00 a.m., the		documented to meet set			
	_	re missing documentation of a			standards.		
	completed fire drill			b On _November 3, 2023_ the			
	*	drill in the first quarter of 2023.	Maintenance Supervisor/designee				
	· ·	drill in the third quarter of 2023.	conducted a fire drill for each of				
		at the time of record review,			the three shifts and documented		
		Directors stated he could not			the results in the facilities Life		
	find the documentar				Safety Binder to meet set		
	aforementioned dril	ls were conducted.			standards. The Administrate		
					verified the drills onNovem	ber 9,	
	These findings were		2023 .				
	Administrator and MD at the exit conference.			2 ALL OTHERS WITH			
				POTENTIAL TO BE AFFECTED:			
	3.1-19(b)				a All residents and all staf		
	3.1.51(c)				and visitors have the potential	to	
					be affected but none were.		
					3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		

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