STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING B. WING		COMPL	X3) DATE SURVEY COMPLETED 05/25/2023		
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD 37TH AVE IT, IN 46342		
(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
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 05/25 Facility Number: 0 Provider Number: 1002 At this Emergency I Waters of Hobart SI found not in compli Preparedness Requi Medicaid Participat CFR 483.73	27/23 00154 155251 289680 Preparedness survey, The killed Nursing Facility was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 42.	E 00	000			
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §48 §483.475(d)(2), §47 §485.625(d)(2), §47 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

(X6) DATE

Jarrett Mitchell Administrator 06/09/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VLWL21 Facility ID: 000154 If continuation sheet Page 1 of 32

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE (COMPL 05/25/	ETED
	ROVIDER OR SUPPLIEF	LED NURSING FACILITY, THE		2901 W	DDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(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)	ΓE	(X5) COMPLETION DATE
	(EACH DEFICIENT REGULATORY OF §491.12, and ESF (2) Testing. The [f exercises to test to annually. The [fact following: (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exercise actual event. (ii) Conduct an adevery 2 years, oppor functional exercise actual event. (ii) Of this section is include, but is not (A) A second full-scommunity-based functional exercise actual event.	RECY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION RD Facilities at §494.62]: Racility] must conduct the emergency plan ility] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based the every 2 years; or lity] experiences an actual adde emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based the following the onset of the ditional exercise at least the posite the year the full-scale cise under paragraph (d)(2) the conducted, that may limited to the following: scale exercise that is or individual, facility-based the; or			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	LE CONTRACTOR OF THE CONTRACTO	
	led by a facilitator discussion using a clinically-relevant set of problem sta messages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and em	ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					

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

Event ID: VLWL21 Facility ID: 000154

If continuation sheet Page 2 of 32

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155251	B. W	ING		05/25	/2023
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUFFLIER			2901 W	37TH AVE		
WATERS	S OF HOBART SKIL	LLED NURSING FACILITY, THE		HOBAR	T, IN 46342		
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For Hospices at	` / -					
	, , ,	espices 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					
	, ,	ict an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
	_	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	facility-based fund	ctional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an ad	dditional exercise every 2					
	years, opposite th	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
		conducted, 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					
	1	and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
	to challenge an er	pared questions designed					
	io challerige all el	nicigency plan.					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					
	per year. The hos	spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					

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

Event ID: VLWL21 Facility ID: 000154

If continuation sheet Page 3 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155251	 JILDING	NSTRUCTION	COMPL 05/25/	ETED
	PROVIDER OR SUPPLIER S OF HOBART SKIL	LED NURSING FACILITY, THE	2901 W	.ddress, city, state, zip cod 37TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	accessible, conduractions facility-based functional exercise emergency event. (ii) Conduct an activate manity-based functional exercise functional exercise emergency event. (iii) Conduct an activate may include, following: (A) A second full-community-based functional exercise functional exercise functional exercise functional exercise functional exercise functional exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emitted the hospice's emergency sementer exercises and emitted the hospice's emergency sementer exercises.	cunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is using in its next required sity based or facility-based to following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based to recise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared				
	conduct exercises plan twice per yea CAH] must do the	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following:				
	(A) When a comm	unity-based exercise is not				

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 4 of 32

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155251	B. WING		05/25/2023
NAME OF F	PROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP COD	
				/ 37TH AVE	
WATERS	S OF HOBART SKIL	LED NURSING FACILITY, THE	HOBAF	RT, IN 46342	
(X4) ID		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	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ct an annual individual,			
	1	tional exercise; or			
		Hospital, CAH] experiences			
		or man-made emergency			
		ation of the emergency			
		s exempt from engaging in ull-scale community based			
		ty-based functional exercise			
		ty-based functional exercise it of the emergency event.			
	_	an [additional] annual			
	· , ,	at may include, but is not			
	limited to the follow	-			
	(A) A second full-scale exercise that is				
	community-based				
		ctional exercise; or			
	1	ck disaster drill; or			
	, ,	exercise or workshop that			
		or and includes a group			
	discussion, using	-			
	_	emergency scenario, and a			
	set of problem sta	-			
	messages, or prep	pared questions designed			
	to challenge an er	nergency plan.			
	(iii) Analyze tł	ne [facility's] response to			
	and maintain docเ	umentation of all drills,			
		s, and emergency events			
	and revise the [fac	cility's] emergency plan, as			
	needed.				
	*[For PACE at §46	60.84(d):1			
		ACE organization must			
		to test the emergency			
	plan at least annu	5			
	organization must	-			
	1 -	ın annual full-scale exercise			
	that is community				
	I -	nunity-based exercise is not			
	accessible, condu	ct an annual individual,			
	facility-based fund				
	1	periences an actual natural			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING		COMPL	LETED	
		155251	B. WIN	IG		05/25	/2023	
		ı	\vdash	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			37TH AVE			
WATERS	S OF HOBART SKII	LED NURSING FACILITY, THE			RT, IN 46342			
	TODAKI OKIL	LLD NOROMO I AOILITI, IIIL		· IODAIN			1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
		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	gency event. In additional exercise every						
	` '	in additional exercise every the year the full-scale or					1	
		e under paragraph (d)(2)(i)						
		e under paragraph (d)(2)(l) conducted that may include,					1	
	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						
		and includes a group						
	discussion, using							
	_	emergency scenario, and a						
	set of problem sta	- ·						
	-	pared questions designed						
	to challenge an er	•						
	(iii) Analyze the F	PACE's response to and						
	maintain documer	ntation of all drills, tabletop						
	exercises, and em	nergency events and revise						
	the PACE's emero	gency plan, as needed.					1	
							1	
	*[For LTC Facilitie	es at §483.73(d):]						
	. , –	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							
		ility] facility experiences an						
	actual natural or n	nan-made emergency that					1	

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

Event ID:

VLWL21

Facility ID: 000154

If continuation sheet

Page 6 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155251	 UILDING	nstruction 	COMPL 05/25/	ETED
	F PROVIDER OR SUPPLIEF RS OF HOBART SKIL	LLED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(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)	ATE	(X5) COMPLETION DATE
	LTC facility is exercequired a full-scalindividual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional et (B) A mock disas (C) A tabletop exled by a facilitator discussion, using clinically-relevant set of problem stalmessages, or preto challenge an er (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in a that is community (A) When a commaccessible, conducted facility-based function of the exercise is exempt from entire in a sexempt from entire is exempt from entire is exempt from entire in a full drills.	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the an annual full-scale exercise				

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 7 of 32

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155251	B. W	ING		05/25/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			37TH AVE		
WATERS	S OF HOBART SKII	LED NURSING FACILITY, THE			T, IN 46342		
		TEED NOTCHAST NOIENT, THE		1105/11			
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	tional exercise following the					
	onset of the emer	~ .					
	' '	ditional annual exercise					
	I -	but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
		tional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is and includes a group					
		.					
	discussion, using a narrated,						
	clinically-relevant emergency scenario, and a set of problem statements, directed						
	•	pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	410 101 7112 0 011101	igonoy pian, ao nocaca.					
	*[For HHAs at §48	34.1021					
	-	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	; or					
	(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					
		aging in its next required					
		nity-based or individual,					
	facility based fund	tional exercise following the					
	onset of the emer	-					
	(ii) Conduct an ad	ditional exercise every 2					

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 8 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251		UILDING	NSTRUCTION	CON	TE SURVEY MPLETED 25/2023
	PROVIDER OR SUPPLIES	R LLED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP CO 37TH AVE T, IN 46342	D -	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is o						
		t limited to the following:					
		I full-scale exercise that is					
	community-based						
	1	ctional exercise; or					
		lisaster drill; or					
	, ,	p exercise or workshop that tor and includes a group					
		— ·					
	discussion, using a narrated, clinically-relevant emergency scenario, and a						
	set of problem statements, directed						
	messages, or prepared questions designed						
	to challenge an e	· · · · · · · · · · · · · · · · · · ·					
	1	IHA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §4						
		e OPO must conduct					
		the emergency plan. The					
	OPO must do the						
		er-based, tabletop exercise					
	-	ast annually. A tabletop					
	1	a facilitator and includes a					
		, using a narrated, clinically					
		ncy scenario, and a set of					
	1 -	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		man-made emergency that					
	· · · · · · · · · · · · · · · · · · ·	n of the emergency plan, the					
		rom engaging in its next					
		exercise following the onset					
	of the emergency						
		PO's response to and					
		ntation of all tabletop					
	exercises, and en	nergency events, and revise					1

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 9 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	X3) DATE SURVEY COMPLETED 05/25/2023	
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 \	ADDRESS, CITY, STATE, ZIP COD N 37TH AVE RT, IN 46342	
(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
	needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCI must do the (i) Conduct a paper at least annually. A group discussion I narrated, clinically scenario, and a sedirected message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCI's emer Based on record reversited to conduct explan at least twice punannounced staff or procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community conduct facility-based functions in the LTC facility or man-made emergency ple from engaging its not community-based of full-scale functional the onset of the actual (ii) Conduct an additional conduct, but is not lia. A second full-scale functional the onset of the actual include, but is not lia.	e RNHCI must conduct the emergency plan. The the following: the chased, tabletop exercise that tabletop exercise is a ted by a facilitator, using a the relevant emergency that of problem statements, the series of the series of the statements the series of the seri	E 0039	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with state and federal medicare and medicaid requirements. E039 — It is the intent of the factor ensure to conduct exercises test the emergency plan at lease to the state of the factor o	t the set red ice ion ith

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 10 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2023	
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(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
1AG	functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or preparechallenge an emerge (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergaccordance with 42 deficient practice of Findings include: Based on records resupervisor on 05/25 11:42 a.m., there was table top exercise of documentation for a exercise was unavairable top exercise was unavairable and interview the Maintenance Supervisor on t	drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, a statements, directed ed questions designed to ency plan. C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. View with the Maintenance is 123 between 09:23 a.m. and as full documentation for the bonducted on 10/15/22 but a community or facility-based lable at the time of the survey. at the time of records review, pervisor stated a community ercise could have been unentation could not be terview later with the ated that the facility had banies and documentation was	TAG	twice per year, including unannounced staff drills using emergency procedures to me set standards. 1. CORRECTIVE ACTION TAKEN: a. On 6/9/23 the Administrand the Maintenance Supervisor/designee conduct community or facility-based exercise and completed documentation for the exercise meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all staff and visitors have the potential be affected but none were. 3. MEASURES TO PREVERECURENCE: a. On 6/9/23 the Administratin serviced the Maintenance Supervisor/designee on the requirement that a community facility-based exercise must be conducted annually and documentation retained to me set standards. (Attachment G. Maintenance Supervisor/designee will work the Administrator to ensure a community or facility-based exercise is conducted and documented to meet set standards. If any issues are discovered, they will be address and resolved immediately. c. The Administrator will	g the et S ator ed a ee to ED: ff
				monitor adherence to the Emergency Preparedness Po	licy

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2023
	PROVIDER OR SUPPLIEF	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (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 APPROPRIAT DEFICIENCY) Manual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to ensure compliance, the Administrator Maintenance Supervisor/desig will review the Emergency Preparedness Policy Manual a conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator present the training results at t Quality Assurance/ Performand Improvement (QA/PI) meeting. Results and system componer	re and nee nd d	
K 0000				will be reviewed by the QA/PI Committee with subsequent place 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 6/23/23.	ans
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 0000		

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet

Page 12 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/25/2023		
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	DDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(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)	ΓE	(X5) COMPLETION DATE
	Facility Number: 0 Provider Number: AIM Number: 100	155251					
	Hobart Skilled Nurs compliance with Re Medicare, 42 CFR of from Fire and the 20 Protection Associat	Code survey, The Waters of sing Facility was found not in equirements for Participation in Subpart 483.90(a), Life Safety 012 edition of the National Fire ion (NFPA) 101, Life Safety ter 19, Existing Health Care 10 IAC 16.2.					
	west wing and adm basement was deter construction and wa one story addition, constructed prior to Type V (111) was a	ory facility consisting of the inistrative area with a partial mined to be of Type II (222) as fully sprinklered. A later consisting of the east wing March 2003, determined to be also fully sprinklered, therefore one building in accordance 19.					
	smoke detectors in to the corridors. Ba detectors are install building is partially powered emergency	re alarm system with hard wired the corridors and spaces open attery powered smoke ed in all resident rooms. The protected by a 230 kW diesely generator. The facility has and had a census of 42 at the					
	Quality Review cor	npleted on 05/30/23					
K 0211 SS=E Bldg. 01							

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet

Page 13 of 32

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155251	B. W	NG		05/25	/2023
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ 37TH AVE		
WATERS	S OF HOBART SKII	LLED NURSING FACILITY, THE			RT, IN 46342		
WAILING				HODAI	(1, 114 +05+2		
(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
		h Chapter 7, and the means					
	_	nuously maintained free of					
		full use in case of					
	1	ss modified by 18/19.2.2					
	through 18/19.2.1						
	18.2.1, 19.2.1, 7.						
		ation and interview, the facility	K 0	211	K211 – It is the intent of the		06/23/2023
		f 6 means of egress were			facility to ensure means of eg		
		ained free of all obstructions			are continuously maintained f		
	_	full instant use in the case of			of all obstructions or impedim		
	_	ency. This deficient practice			to full instant use in the case)†	
		roximately 15 staff and			fire or other emergency and		
	residents.				maintain exit discharge doors		
					free of impediments to full ins		
	Findings include:				use in the case of fire or other		
					emergency to meet set standa		
		vation during a tour of the			1. CORRECTIVE ACTIONS	3	
	•	aintenance Supervisor and			TAKEN:		
		tant #1 on 05/25/23 between			a. On 5/26/23 the Maintena		
		5 p.m., the South 100 Hall			Supervisor/designee removed		
		over 20 cardboard boxes.			cardboard boxes from the sou	ith	
		ew at the time of observations,			100 hall corridor to meet set		
		apervisor agreed there was a			standards. The Administrator		
	1	corridor and stated a delivery			verified the work on 5/26/23.		
	1	ıld have been unpacked and			b. On 5/26/23 the		
	taken to designated	areas.			Maintenance Supervisor/design		
	The findings	versions ad with the Maintenance			repaired the exit door in the m		
		reviewed with the Maintenance			dining area to meet set standa		
		e Maintenance Supervisor			The Administrator verified the	work	
	during the exit con	iciciice.			on 5/26/23.		
	2 1 10(b)				2. ALL OTHERS WITH	ED.	
	3.1-19(b)				POTENTIAL TO BE AFFECT		
	2 Paged on absent	ation and interview the facility			a. All residents and all staf		
		ation and interview, the facility of 7 exit discharges doors were			and visitors have the potential		
		C			be affected but none were. O 5/26/23 the Maintenance	11	
	_	s to full instant use in the case ergency in accordance with LSC				اه ما	
		1.7.1 states where a door			Supervisor/designee inspecte		
					corridors and exit doors and for	Juliu	
		d to be equipped with panic or			no other negative findings.	:NIT	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/25/2023			
	NAME OF P	ROVIDER OR SUPPLIEF	• {	•		ADDRESS, CITY, STATE, ZIP COD		
			LLED NURSING FACILITY, THE			/ 37TH AVE RT, IN 46342		
	(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	ATE	COMPLETION
_	TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
			rce not to exceed 15 lbf (66 N)			REOCCURRENCE:		
			ar or push pad and latches.			a. On 6/9/23 the Administra	ator	
	This deficient practice could affect approximately 20 staff and residents near the Main Dining area.					in serviced the Maintenance	41	
		20 staff and residen	its near the Main Dining area.			Supervisor/designee and all o		
		Findings include:				staff on the requirement that t		
		rindings include:				corridor means of egress are		
		Rosed on observative	one with the Maintenance			remain free of obstructions ar		
		Based on observations with the Maintenance Supervisor and Maintenance Assistant #1 on				exit discharge doors are to refree of impediments to full ins		
	05/25/23 between 11:50 a.m. and 1:55 p.m., the exit					use to meet set standards.	lant	
	door in the Main Dining area was equipped with					b. Maintenance		
		panic hardware, but the door would not open on				Supervisor/designee will inspe	ect.	
		-	the Maintenance Supervisor			all corridor means of egress	501	
		•	he door and took excessive			throughout the facility weekly	for	
		-	oor on the fourth try. Based on			obstructions and will inspect a		
		-	e of observation, the			exit discharge doors for	•••	
			visor agreed it took excessive			impediments as a part of the		
			ait door and was unaware of			facility's Preventive Maintena	nce	
		the issue				Program and document those		
						inspection results as appropri		
		The findings were r	reviewed with the Maintenance			If any issues are discovered,		
		Assistant #1 and the	e Maintenance Supervisor			will be addressed and resolve	d	
		during the exit conf	ference.			immediately. The Maintenand	ce	
						Supervisor/designee will revie	•W	
		3.1-19(b)				with the Administrator the		
						inspection results. (Attachmer	nt A)	
						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	ınce	
						Supervisor/designee to the		
						Administrator monthly and the	;	
						Administrator will present the inspection results at the mont	hlv	
				1		I mapeolion results at the HOHL	1 1 I V	1

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/25/2023
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP CO / 37TH AVE RT, IN 46342	DD
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE COMPLETION PROPRIATE DATE
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.		Quality Assurance/Perf Improvement (QA/PI) in Inspection results and a components will be revithe QA/PI Committee with equality and implement of the end o	neeting. system iewed by vith rrection ented as ensure ed. I le ce with nents.

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 16 of 32

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155251	B. W	NG		05/25	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			V 37TH AVE		
WATERS	S OF HOBART SKI	LLED NURSING FACILITY, THE			RT, IN 46342		
(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	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		l-Fired Heater Rooms					
	, -	er than 100 square feet)					
	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)						
	e. Trash Collectio						
	(exceeding 64 ga	,					
		orage Rooms/Spaces					
	(over 50 square for	•					
	Hazard - see K32	classified as Severe					
		on and interview, the facility	K 0	221	K321– It is the intent of the fa	cility	06/23/2023
		corridor doors to 1 of 1 linen	I K U	321	to ensure the corridor door to	Cility	00/23/2023
		h is a hazardous area			hazardous area doors, such a	15	
	-	tible storage and greater than			storage room door, is provide		
		provided with a self-closing			with a self-closing device to m		
	device which woul	-			set standards.		
		e and latch into the door frame.			1. CORRECTIVE ACTIONS	S	
		tice could affect approximately			TAKEN:		
	15 residents and sta				a. On 5/26/23 the		
					Maintenance Supervisor/design	gnee	
	Findings include:				replaced/repaired the self clos	sing	
					device on the linen storage ro	om	
	Based on observati	ons during a tour of the facility			door so that it self closes and		
	with the Maintenar	nce Supervisor and			latches into the frame to meet	set	
		tant #1 on 05/25/23 between			standards. The Administrator		
	11:50 a.m. and 1:53	5 p.m., the linen storage room, a			verified the work on 5/26/23.		
	_	room that was greater than 50			2. ALL OTHERS WITH		
		uipped with self-closing device			POTENTIAL TO BE AFFECT		
		to the frame when tested.			a. All residents and all staf		
		at the time of observation, the			and visitors have the potential		
	_	rvisor agreed the room was			be affected but none were. O	n	
		s larger than 50 square feet,			5/26/23 the Maintenance		
		latching mechanism would			Supervisor/designee inspecte		
	need to be replaced	i.			hazardous area doors for self		
	Findings 1	useed with the Meintener			closing devices and found no	otner	
		ussed with the Maintenance intenance Assistant #1 at exit			negative findings.	:NT	
	conference.	michanice Assistant #1 at exit			3. MEASURES TO PREVE	: IN I	
	conference.				a. On 6/9/23 the Administr	rator	
	I		1		a. On orazo ine Aurillisi	alui	Ī

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155251	B. W	ING		05/25/	2023
	PROVIDER OR SUPPLIER	LED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	3.1-19(b)				in-serviced the Maintenance		
					Supervisor/designee/all staff o	n	
					the requirement that all hazard	dous	
					area doors must be protected	with	
					a self-closing device and self		
					closes and latches into the fra	me	
					to meet set standards.		
					b. Maintenance		
					Supervisor/designee will inspe	ect	
					all hazardous area doors throughout the facility monthly	to	
					ensure there is a self-closing	เบ	
					device and it self closes and		
					latches into the frame as a par	rt of	
					the facility's Preventive	11.01	
					Maintenance Program and		
					document those inspection res	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra	tor	
					the inspection results.		
					(Attachment B)		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING CORRECTIVE ACTION:		
						ill	
					a. The inspection results w be presented by the Maintena		
					Supervisor/designee to the	1.00	
					Administrator monthly and the	!	
					Administrator will present the		
					inspection results at the month	nlv	
					Quality Assurance/Performand	-	
					Improvement (QA/PI) meeting		

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

Event ID:

VLWL21

Facility ID: 000154

4 If continuation sheet

Page 18 of 32

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/25/2023
		2901 V	V 37TH AVE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
			Inspection results and system components will be reviewed 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 6/23/23	n as
Fire Alarm - Out o Where required fir services for more period, the authori be notified, and th evacuated or an a provided for all pa shutdown until the	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has			
Based on record rev failed to provide a c for the protection of procedures to be fol alarm system has to four hours or more accordance with LS deficient practice af Findings include: Based on records re Supervisor on 05/25	omplete 1 of 1 written policy residents indicating lowed in the event the fire be placed out of service for in a twenty four hour period in C, Section 9.6.1.6. This fects all occupants.	K 0346	K346— It is the intent of the facto ensure to provide a comple written policy for the protection residents indicating procedure be followed in the event the final arm system has to be placed out of service for four hours of more in a twenty-four-hour pein accordance with LSC, Sect 9.6.1.6 to meet set standards. 1) CORRECTIVE ACTIONS TAKEN: a) On 5/26/23 the	n of es to re d
•	NFPA 101 Fire Alarm System Fire Alarm - Out or Where required fir services for more period, the authoribe notified, and the evacuated or an aprovided for all pashutdown until the been returned to send a cordance with LS deficient practice afficient practice af	DENTIFICATION NUMBER 155251 PROVIDER OR SUPPLIER S OF HOBART SKILLED NURSING FACILITY, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.	NFPA 101 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Supervisor on 05/25/23 between 09:23 a.m. and	PROVIDER OR SUPPLIER S OF HOBART SKILLED NURSING FACILITY, THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NEPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service Fire Alarm System has to be placed out of services for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Supervisor on 05/25/23 between 09:23 a.m. and

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet

Page 19 of 32

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/25/2023			
		ROVIDER OR SUPPLIER OF HOBART SKIL	LED NURSING FACILITY, THE		2901 W	ADDRESS, CITY, STATE, ZIP COD 37TH AVE IT, IN 46342		
	(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)	TE	(X5) COMPLETION DATE
		contacting the India the IDOH Gateway https://gateway.isdr or by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g the record review, t acknowledged the f provided stated to c the IDOH Gateway listed above. This finding was re-	link at link a			Supervisor updated the fire war plan to include contacting the Indiana Department of Health the IDOH gateway link https://gateway.isdh.in.gov as primary method or by the secondary method by complet the Incident Reporting form an emailing it to incidents@isdh.in.gov to meet standards. 2) ALL OTHERS WITH POTENTIAL TO BE AFFECTE a) All residents and all staff and visitors have the potential be affected but none were. 3) MEASURES TO PREVENTE REOCCURRENCE: a) On 6/9/23 the Administratin-serviced the Maintenance Supervisor/designee on the requirement that the fire watch plan must include IDOH gatew link as primary method and en address as secondary method meet set standards. b) Maintenance Supervisor/designee will ensu the IDOH gateway link is primare method and email address is secondary and included in the watch plan as a part of the facility's Emergency Preparedness Manual. If any issues are discovered, they will addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the results.	via the ing id set ED: to NT ator ator re ary fire	

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	COMF	E SURVEY PLETED 5/2023
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP C V 37TH AVE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				c) The Administrator monitor adherence to a Fire Plan/Fire Watch at the documentation is in the documentation and the document of the	the Facilities and validate in place. N: to ensure instrator and cor/designee is fire plan inecessary sent the Quality ince imponents in QA/PI in quent plans in and in ed compliance in the ince with iments.	
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a				

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

Event ID:

VLWL21

Facility ID: 000154

If continuation sheet

Page 21 of 32

PRINTED: 06/15/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPL	
		155251	B. WING		05/25/	/2023
NAME OF	DDOWNED OD CHIDDI IEI		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF		2901 V	V 37TH AVE		
WATERS	S OF HOBART SKIL	LED NURSING FACILITY, THE	HOBAI	RT, IN 46342		
(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 APPROPRIATE	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		nd readily available.				
	a) Date sprinkler	system last checked				
	b) Who provided	system test			ļ	
	c) Water system supply source Provide in REMARKS information on					
		non-required or partial				
automatic sprinkler system.						
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility					
			K 0353	K353 – It is the intent of the		06/23/2023
		he ceiling construction of 1 of 1		facility to ensure to maintain the	Э	
		medicine rooms. The ceiling		ceiling construction of nurses		
	_	l gases around the sprinkler		stations and medicine rooms to	1	
	_	kler to operate at a specified		meet set standards.		
	_	13, 2010 edition, 8.5.4.11 states		4 CORRECTIVE ACTIONS		
		on the sprinkler deflector and nall be selected based on the		1.CORRECTIVE ACTIONS TAKEN:		
		d the type of construction.		1.On 5/26/23 the		
		ice affects approximately 20		Maintenance Supervisor/design	166	
	residents and staff.	are unions approximately 20		sealed the one-inch ceiling	100	
				penetration with a one hour fire	<u>.</u>	
	Findings include:			rated material in the suspended		
				ceiling of the west end nurses		
	Based on observation	ons during a tour of the facility		station and in the Central Hall	ļ	
	with the Maintenan	-		nurses station to meet set	ļ	
		tant #1 on 05/25/23 between		standards. The Administrator	ļ	
		5 p.m., in the suspended ceiling		verified the work on 5/26/23.	ļ	
		station there was a 1 inch		2.ALL OTHERS WITH	_	
		from cables running into the		POTENTIAL TO BE AFFECTEI		
	-	ion could delay the activation		1.All residents and all staff		
		stalled on the suspended		and visitors have the potential t	.0	
	-	e, the Central Hall nurses		be affected but none were.	ļ	
		inch gap in the ceiling Based		3.MEASURES TO PREVENT		
		time of the observations, the visor agreed there were ceiling		REOCCURRENCE:		
	•	ould need to be fixed.		1.On 6/9/23 the Administrator in-serviced the		
	I Penenanons and We	Julia licea to oc linea.	ı	Autilitionator ill-serviced life		I

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

The finding was reviewed with the Maintenance

Event ID: VLWL21 Facility ID: 000154

If continuation sheet

Maintenance Supervisor/designee

on the requirement that the ceiling

Page 22 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	NIDER/SUPPLIER/CLIA FICATION NUMBER 51	A. BUILDING B. WING	01	COMPLETED 05/25/2023
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED N	URSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(X4) ID SUMMARY STATEMI PREFIX (EACH DEFICIENCY MUS' TAG REGULATORY OR LSC IDE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Assistant #1 and Maintenan the exit conference.	ce Supervisor during		construction must be maintain with no penetrations to meet s standards.	
3.1-19(b)			2.Maintenance Supervisor/designee will ensu the ceiling construction is maintained with no penetration as a part of the facility's Preve Maintenance Program and document those inspection res as appropriate. If any issues discovered, they will be addres and resolved immediately. Th Maintenance Supervisor/desig will review with the Administrat the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4.MONITORING CORRECTI ACTION: 1.The inspection results to be presented by the Maintena Supervisor/designee to the Administrator monthly and 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 the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. (Attachment F, F1, F2)	ns ntive sults are ssed e gnee tor VE will nce hly be

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

Event ID:

VLWL21 Facilit

Facility ID: 000154

If continuation sheet

Page 23 of 32

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155251	B. W	NG		05/25/	/2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			/ 37TH AVE		
 WATERS	S OF HOBART SKII	LLED NURSING FACILITY, THE			RT, IN 46342		
					1		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements.		
					Our date of compliance is		
					6/23/23.		
K 0354	NFPA 101						
SS=F	Sprinkler System	- Out of Service					
Bldg. 01	Sprinkler System						
5		er system is impaired, the					
	· ·	on of the impairment has					
		areas or buildings involved					
		d risks are determined,					
	recommendations	•					
		lesignated representative,					
	-	tment and other authorities					
	·	n have been notified. Where					
		em is out of service for more					
	than 10 hours in a	a 24-hour period, the					
	building or portion	of the building affected are					
	evacuated or an a	approved fire watch is					
	provided until the	sprinkler system has been					
	returned to servic	e.					
		, 9.7.5, 15.5.2 (NFPA 25)					
		view and interview, the facility	K 0	354	K354- It is the intent of the fac	ility	06/23/2023
	-	of 1 correct written policies in			to ensure to provide correct w		
		natic sprinkler system has to be			policies in the event the autom		
	-	ce for 10 hours or more in a			sprinkler system has to be pla		
	-	ccordance with LSC, Section			out of service for 10 hours or r		
		quires sprinkler impairment			in a 24 hour period in accorda		
		with NFPA 25, 2011 Edition,			with LSC, section 9.7.5 to mee	et .	
		e Inspection, Testing and			set standards.		
		nter-Based Fire Protection			1) CORRECTIVE ACTIONS		
	•	5, 15.5.2 requires nine			TAKEN:		
	_	impairment coordinator shall			a) On 5/26/23 the		
	·) (b) states a fire watch should			Administrator/Maintenance	1-4-1-	
	_	ersonnel who continuously			Supervisor updated the Fire W	atch	
	-	area. Ready access to fire			policy to include: Contact the		
	extinguishers and the	he ability to promptly notify	1		Indiana Department of Health	vıa	

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 24 of 32

	OF CORRECTION	IDENTIFICATION NUMBER 155251	A. BUILDING B. WING	01	COMPLETED 05/25/2023
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(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
	consider. During the should not only be I sure that the other fi building such as egrare available and fur deficient practice confacility. Findings include: Based on records re Supervisor on 05/25 11:42 a.m., the fire contacting the India the IDOH Gateway https://gateway.isdhor by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g the record review, the acknowledged the fiprovided stated to contact the IDOH Gateway listed above. This finding was revenue.	are important items to e patrol of the area, the person ooking for fire, but making re protection features of the ess routes and alarm systems netioning properly. This huld affect all occupants in the view with the Maintenance //23 between 09:23 a.m. and watch plan failed to include na Department of Health via link at .in.gov as the primary method method when the IDOH ational by completing the form and e-mailing it to ov. Based on interview during the Maintenance Supervisor are watch documentation ontact the IDOH but not via link or at the e-mail address viewed with the Maintenance supervisor during the supervisor during the maintenance Supervisor during the supervisor duri		the IDOH Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method when the I Gateway is nonoperational by completing the Incident Reporter and emailing it to incidents@isdh.in.gov to mee standards. 2) ALL OTHERS WITH POTENTIAL TO BE AFFECT a) All residents and all staff and visitors have the potential be affected but none were. 3) MEASURES TO PREVE REOCCURRENCE: a) Maintenance Supervisor/designee will contite authorities having jurisdict the sprinkler system is out of service for more than 10 hour 24-hour period per facility poli as a part of the facility's Preve Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designer will review with the Administrative inspection results. b) 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 we man and the properties of the preventative Maintenance and the preventa	rting t set ED: f I to NT act tion if s in a cy entive sults are essed the gnee gnee ator

DEPARTMENT OF HEALTH AND HUMAN SERVICES

06/15/2023 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(3) DATE SURVEY COMPLETED 05/25/2023
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				be presented by the Maintenand Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly 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 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 6/23/23.	/ :
K 0511 SS=D Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 2 or kitchen were secure personnel. NFPA 7 Energized parts of secure par	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0511	K511 – It is the intent of the facility to ensure electrical pane in the kitchen are secured from non- authorized personnel to moset standards. 1. CORRECTIVE ACTIONS	

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

specified in 230.62(B).

(A) Enclosed. Energized parts shall be enclosed

so that they will not be exposed to accidental

Event ID:

VLWL21

Facility ID: 000154

TAKEN:

If continuation sheet

a. On 6/9/23 the Maintenance

Supervisor/designee repaired the

Page 26 of 32

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
15525		155251	B. WING		05/25/2023
			GED E	ET ADDRESS SET STATE THE SOR	
NAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD	
				1 W 37TH AVE	
WATERS	S OF HOBART SKI	LLED NURSING FACILITY, THE	HOE	3ART, IN 46342	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	contact or shall be	guarded as in 230.62(B).		electrical panel locks in the	•
	(B) Guarded. Energ	gized parts that are not enclosed		kitchen to meet set standa	rds.
	shall be installed or	n a switchboard, panelboard, or		The Administrator verified	the
	control board and g	guarded in accordance with		repairs on 6/9/23	
	110.18 and 110.27	. Where energized parts are		2. ALL OTHERS WITH	
	guarded as provide	ed in 110.27(A)(1) and (A)(2), a		POTENTIAL TO BE AFFE	CTED:
	means for locking	or sealing doors providing		a. All residents and all s	staff
	access to energized	l parts shall be provided. This		and visitors have the poter	itial to
	deficient practice c	ould affect staff in the service		be affected but none were.	On
	hall.			6/9/23 the Maintenance	
				Supervisor/designee inspe	cted all
	Findings include:			electrical panels in the kitc	hen
				and found no other negative	re l
	Based on observati	on with Maintenance		findings.	
	Supervisor and Ma	intenance Assistant #1 on		3. MEASURES TO PRE	VENT
	05/25/23 between	11:50 a.m. and 1:55 p.m., the		REOCCURRENCE:	
	electrical panels in	the kitchen were unlocked and		a. On 6/9/23 the Admin	strator
	open when tested.	Based on interview at the time		in-serviced the Maintenand	e
	of observation, the	Maintenance Supervisor		Supervisor/designee on the	e
	stated the latch of o	one panel was missing and the		requirement that electrical	panels
	other would not loo	ck when turned with a key.		in the kitchen must be lock	ed to
				meet set standards.	
	Findings were disc	ussed with the Maintenance		b. Maintenance	
	Supervisor and Ma	intenance Assistant #1 at exit		Supervisor/designee will in	spect
	conference.			all kitchen panels monthly	to
				ensure they remain locked	as a
	3.1-19(b)			part of the facility's Preven	tive
				Maintenance Program and	
				document those inspection	results
				as appropriate. If any issu	ies are
				discovered, they will be ad	
				and resolved immediately.	
				Maintenance Supervisor/de	esignee
				will review with the Adminis	strator
				the inspection results.	
				c. The Administrator wil	I
				monitor adherence to the	
				Preventative Maintenance	
				schedule and validate the	
				Preventative Maintenance	

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 27 of 32

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC.	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
		155251	B. WING		05/25/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		RT, IN 46342		
		STATEMENT OF DEFICIENCIE	<u> </u>	1	(V5)	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
K 0521	NFPA 101			documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results we be presented by the Maintena Supervisor/designee to the 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 at the QA/PI Committee with subsequent plans of correction developed and implemented at deemed necessary to ensure compliance is maintained. (Attachment C) This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/23/23.	nce inly ce in by n	
SS=E	HVAC					
Bldg. 01	comply with 9.2 ar	n, and air conditioning shall nd shall be installed in				
	accordance with the specifications.	ne manutacturer's				
	18.5.2.1, 19.5.2.1,	9.2				
	Based on observation failed to ensure 2 of used as a portion of	on and interview, the facility 7 egress corridors were not a return air system/plenum for or air conditioning (HVAC)	K 0521	K521 - It is the intent of the factor to ensure egress corridors are used as a portion of a return a system/plenum for heating,	not	

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

ductwork serving adjoining areas. LSC 19.5.2.1

Event ID:

VLWL21

Facility ID: 000154

If continuation sheet

system/plenum for heating,

ventilating, or air conditioning

Page 28 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251		UILDING	onstruction 01	(X3) DATE COMPL 05/25 /	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2901 W 37TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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	
	ductwork and relate accordance with NF Installation of Air C Systems. NFPA 90 4.3.12.1.1 states egras a portion of a supsystem serving adjopermitted by 4.3.12 deficient practice costaff and visitors on Findings include: Based on observation Supervisor during a a.m. to 1:55 p.m. or rooms and support 122 through 136 we a portion of a return interview at the tim Maintenance Super of the issue and an equipped with an air This finding was re	ons with the Maintenance tour of the facility from 11:50 in 05/25/23, resident sleeping offices 111 through 119 and ere using the egress corridor as in air system. Based on the observations, the visor stated they were aware operable HVAC unit supplies oom and each room is not			(HVAC) ductwork serving adjourness to meet set standards. 1) CORRECTIVE ACTIONS TAKEN: The facility respectfully submit the following plan of correction a credible allegation of complito the above-mentioned regular prefix K521. We have applied continuing waiver for financial hardship. Please see attached documentation (Attachment E1,E2).	s n as ance ation, for a		
K 0920 SS=D Bldg. 01	Extens Electrical Equipmone Extension Cords Power strips in a pused for compone	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment						

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 29 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPL			ETED		
155251		B. WING 05/25/2			2023		
			<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1			37TH AVE		
WATERS OF HOBART SKILLED NURSING FACILITY, THE							
WATERS	OF HUDAR I SKIL	LED NURSING FACILITY, THE		HUDAR	T, IN 46342		
(X4) ID	SUMMARY 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 APPROPRIATE	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(PCREE) assembl	les that have been					
	assembled by qua	lified personnel and meet					
		0.2.3.6. Power strips in					
		cinity may not be used for					
		personal electronics),					
	, -	n care resident rooms that					
		E. Power strips for PCREE					
		r UL 60601-1. Power strips					
		the patient care rooms					
) meet UL 1363. In					
		ooms, power strips meet					
	•	s. All power strips are					
		precautions. Extension					
	-	d as a substitute for fixed					
	-	re. Extension cords used					
		moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
	,	9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 0920		K920 – It is the intent of the facility		06/23/2023
		f 1 power strips were not used			to ensure power strips are not		
		xed wiring to provide power			used as a substitute for fixed		
	equipment with a hi				wiring to provide power equipn		nt
		0.8 state unless specifically			with a high current draw to me	et	
	*	lexible cords and cables shall			set standards.		
		as a substitute for fixed wiring.			1. CORRECTIVE ACTIONS	5	
	•	ice could affect up to 2 staff			TAKEN:		
	and an unknown am	nount of residents.			a. On 5/26/23 the Maintena		
					Supervisor/designee removed		
	Findings include:				power strip from the microwav	e to	
					meet set standards. The		
	Based on observations during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1 on 05/25/23 between 11:50 a.m. and 1:55 p.m., a microwave (high power				Administrator verified the remo	oval	
					of the cord on 5/26/23.		
					2. ALL OTHERS WITH		
					POTENTAL TO BE AFFECTE	D:	
	draw equipment) wa	as plugged into and supplied			a. All residents and all staff		
	power by a power s	trip. Based on interview at the			and visitors have the potential	to	
	time of observation,	, the Maintenance Supervisor			be affected but none were. Or	า	
	acknowledged power	er strips were supplying power			5/26/23 the Maintenance		

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet Page 30 of 32

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155251		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/25/2023	
	PROVIDER OR SUPPLIE S OF HOBART SKI	R LLED NURSING FACILITY, THE	2901 V	ADDRESS, CITY, STATE, ZIP COD V 37TH AVE RT, IN 46342	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	to high power draw plug the microwav observation.	v equipment and was able to e in an outlet at the time of ussed with the Maintenance intenance Assistant #1 at exit		Supervisor/designee inspector rooms throughout the facility power strips and found no ot negative findings. 3. MEASURES TO PREV REOCCURRENCE: a. On 6/9/23 the Administrin-serviced the Maintenance Supervisor/designee and allost staff on the requirement that strips are not to be used as a substitute for fixed wiring to provide power equipment with high current draw in the facility meet set standards. b. Maintenance Supervisor/designee will inspand in rooms throughout the facility monthly and remove any non-approved power strips for as a part of the facility's Prev Maintenance Program and document those inspection reas appropriate. If any issued discovered, they will be addrand resolved immediately. The Maintenance Supervisor/des will review with the Administration 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 of the presented by the Maintenance Supervisor/designee to the Supervisor/designee to	ed all for her ENT rator other power a heat ty to pect lity pund rentive esults are essed the ignee rator will

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

Event ID:

VLWL21 Facility ID: 000154

If continuation sheet

Page 31 of 32

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155251	B. WI	NG		05/25/	2023
NAME OF PROVIDER OR SUPPLIER WATERS OF HOBART SKILLED NURSING FACILITY, THE				2901 W HOBAR	ADDRESS, CITY, STATE, ZIP COD 37TH AVE T, IN 46342		
(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 APPROPRIATE		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	•	
					Quality Assurance/Performand		
				Improvement	Improvement (QA/PI) meeting	•	
					Inspection results and system		
					components will be reviewed by	ру	
					the QA/PI Committee with		
					subsequent plans of correction	1	
					developed and implemented a	S	
					deemed necessary to ensure		
					compliance is maintained.		
					(Attachment D)		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements.		
					Our date of compliance is		

6/23/23.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VLWL21 Facility ID: 000154 If continuation sheet Page 32 of 32