STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. BUILDING -- B. WING	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/21/25 Facility Number: 000519 Provider Number: 155571 AIM Number: 100287230 At this Emergency Preparedness survey, The Waters of Dunkirk Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 46 and had a census of 31 at the time of this survey. Quality Review completed on 04/24/25	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.cDISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Max Richardson	Intermin Administrator	05/05/2025

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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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/21/25 Facility Number: 000519 Provider Number: 155571 AIM Number: 100287230 At this Life Safety Code survey, The Waters of Dunkirk Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V(111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery-operated smoke detectors in the resident rooms. The facility has a capacity of 46 and had a census of 31 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/24/25	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.cDISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	

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K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Battery-Operated Emergency Lights and Signs Test Log" documentation with the Interim Administrator and the Maintenance Director at 12:05 p.m. on 04/21/25, an itemized list by light location for monthly and annual 90-minute battery operated light testing documentation for the most recent twelve month period was not available for review. The	K 0291	**K291** – It is the intent of the facility to ensure to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.The Maintenance Supervisor/designee will conduct the battery-operated emergency lights and signs test with an itemized list by light location for monthly and annual 90 minute battery operated light testing and with documentation results in the facilities life safety binder to meet set standards by 5/23/2025. The Administrator or designee will verify the work by 5/23/2025. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.The Administrator or designee will inservice the Maintenance Supervisor/designee on the requirement to ensure to maintain battery powered emergency lighting systems including conducting and documenting all required testing to meet set standards by 5/8/2025.	05/23/2025

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	aforementioned documentation only listed monthly testing for January 2025 through April 2025 for one location identified as the "Generator Room". Based on interview at 12:05 p.m. on 04/21/25, the Maintenance Director stated the "Generator Room" battery light location is actually the emergency generator automatic transfer switch location in the housekeeping room, the facility also has a battery operated emergency light located at the outdoor emergency generator location and additional monthly and annual 90-minute battery operated light testing documentation for the most recent twelve month period was not available for review. Based on observations with the Interim Administrator and the Maintenance Director at 2:44 p.m. on 04/21/25, one battery operated emergency light was located at the emergency generator automatic transfer switch location in the housekeeping room. Based on observations with the Interim Administrator and the Maintenance Director at 2:51 p.m. on 04/21/25, one battery operated emergency light was located at the emergency generator location outside the facility on the southwest side of the property. Each battery light functioned when its respective test button was pushed. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		2.Maintenance Supervisor/designee will ensure to maintain battery powered emergency lighting systems are maintained and conducting and documenting all required testing as a part of the facility's monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator 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 CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (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.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/23/2025.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Interim Administrator and the Maintenance Director at 10:50 a.m. on 04/21/25, the air pressure gauge for the facility's dry sprinkler system accelerator in the water storage tank room read zero. Based on interview at 10:50 a.m. on 04/21/25, the Maintenance Director stated the accelerator needs	K 0353	**K353** – It is the intent of the facility to ensure to maintain the automatic sprinkler systems in accordance with NFPA 25 and to ensure to provide written documentation or other evidence that the sprinkler system components had been inspected and tested and to ensure indoor sprinkler system water supply water tank storage rooms are maintained free of material that could present a fire exposure hazard and is maintained free of accumulated material on or near water supply storage tank parts in accordance with NFPA 25 requirements to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.The licensed sprinkler contractor will repair the facility's dry sprinkler system accelerator in the water storage tank to meet set standards by 5/23/2025. The Administrator or designee will verify the work by 5/23/2025. 2.The Maintenance Supervisor will conduct the	05/23/2025

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	repair, the contractor is aware of it, but repair or replacement has not been scheduled. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide written documentation or other evidence that the sprinkler system components had been inspected and tested for 9 months of the most recent 12 month period. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 8.3.1.2 states electric motor driven fire pumps shall be operated monthly. Section 8.3.2.3 states the electric pump shall run a minimum of 10 minutes. Section 8.3.3.1 states an annual test of each pump assembly shall be conducted by qualified personnel under minimum, rated, and peak flows of the fire pump by controlling the quantity of water discharged through approved test devices. Section 8.3.3.1.1 states if available suction supplies do not allow flowing of 150 percent of the rated pump capacity, the fire pump shall be permitted to operate at		annual/weekly/monthly electric fire pump churn test and the annual fire pump test and documented the results in the facilities life safety binder to meet set standards by 5/23/2025. The Administrator or designee will verify the work by 5/23/2025. 3.The Maintenance Supervisor removed all combustible boxes, window unit ac, floor buffing machine, spare corridor door and additional misc items from the indoor sprinkler system water supply water tank storage room to meet set standards by 5/23/2025. The Administrator or designee will verify the work by 5/23/2025. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.The Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to maintain the sprinkler system per the requirements of NFPA 25 including conducting the annual/weekly/monthly electric fire pump churn test and the annual fire pump test and documenting the results and to ensure the indoor sprinkler system water supply water tank storage room is not used as a storage room to	

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	maximum allowable discharge. Section 8.3.3.1.2 state the annual test shall be conducted as described in 8.3.3.1.2.1, 8.3.3.1.2.2, or 8.3.3.1.2.3. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of "Annual/Weekly/Monthly Electric Fire Pump Churn Test" documentation with the Interim Administrator and the Maintenance Director at 1:10 p.m. on 04/21/25, monthly fire pump inspection and testing documentation for nine months of the most recent twelve month period was not available for review. The aforementioned inspection and testing documentation only included the three month period of January 2025 through March 2025. Annual fire pump testing was also not available for review. Based on interview at 1:10 p.m. on 04/21/25, the Maintenance Director stated the facility just started documenting monthly fire pump testing in January 2025 and agreed additional monthly and annual fire pump testing documentation was not available for review. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. The facility failed to ensure 1 of 1 indoor sprinkler system water supply water tank storage rooms was maintained free of material that could present a fire exposure hazard and was maintained free of accumulated material on or near water supply storage tank parts in accordance with NFPA 25 requirements. NFPA 25, Standard for		meet set standards by 5/8/2025. 2.Maintenance Supervisor/designee will ensure to maintain the sprinkler system per the requirements of NFPA 25 including conducting the annual/weekly/monthly electric fire pump churn test and the annual fire pump test and documenting the results and to ensure the indoor sprinkler system water supply water tank storage room is not used as a storage room as a part of the facility's Annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system	

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	the Inspection, Testing, and Maintenance of Water-Based Fire Protection, 2011 Edition, Section 9.2.5.2 states the area surrounding the tank and supporting structure, where provided, shall be inspected quarterly to ensure that the following conditions are met: (1) The area is free of combustible storage, trash, debris, brush, or material that could present a fire exposure hazard. (2) The area is free of the accumulation of material on or near parts that could result in accelerated corrosion or rot. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Interim Administrator and the Maintenance Director at 1:48 p.m. on 04/21/25, the indoor sprinkler system water supply water tank storage rooms containing the facility's dry sprinkler system was also being used as a storage room. Combustible boxes were stored in the room along with window unit air conditioners, a floor buffing machine, a spare corridor door and additional miscellaneous items not affiliated with sprinkler system water supply components. In addition, a combustible box was stored directly on top of the water supply tank's piping to the dry sprinkler system riser. Based on interview at 1:48 p.m. on 04/21/25, the Interim Administrator and the Maintenance Director agreed the indoor sprinkler system water supply water tank storage room containing the facility's dry sprinkler system was also being used as a storage room. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference.		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 5/23/2025.**	

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K 0363 SS=E Bldg. 01	3.1-19(b) NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 3 corridor doors to the kitchen had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Interim Administrator and the Maintenance Director at 2:18 p.m. on 04/21/25, the serving window in the kitchen for the main dining room was equipped with two swinging doors with self closing hinge hardware on the wall side of each door. Each door was also equipped with wall mounted magnetic releasing devices set to release the doors with fire alarm system activation. Each door was not equipped with positive latching hardware to latch each door into the door frame. The door set was equipped with a hasp type locking device to lock the doors. The north door in the door set was equipped with a slide bolt at the top of the door to lock the door into the door frame. The main dining room was open to the corridor which caused the kitchen to be open to the corridor because the kitchen window door set was not equipped with positive latching devices to latch each door into the door frame. Based on interview at 2:18 p.m. on 04/21/25, the Maintenance Director agreed the serving window door set was not equipped with a positive latching device to latch each door into the door frame and would not	K 0363	**K363** – It is the intent of the facility to ensure corridor doors to the kitchen have no impediments to closing and latching into the door frame and would resist the passage of smoke to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a The Maintenance Supervisor/designee will have installed positive latching devices to latch each door into the door frame at the serving window door set to meet set standards by 5/23/2025. The Administrator or designee will have verified the repair by 5/23/2025. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all doors and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a By 5/8/2025 the Administrator or designee will have in serviced the Maintenance Supervisor/Dietary Staff on the requirement to ensure serving window has a positive latch to	05/23/2025

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	resist the passage of smoke. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		meet set standards. b Maintenance Supervisor/designee will ensure corridor doors close, latch into the door frame and ensure there are no gaps as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator or designee the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (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**	

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			allegation of compliance with all regulatory requirements. Our date of compliance is 5/23/2025.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure electrical receptacles in 2 of over 20 resident sleeping rooms were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and	K 0511	**K511**– It is the intent of the facility to ensure electrical receptacles in resident sleeping rooms are properly grounded in accordance with NFPA 70 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a The Maintenance Supervisor/licensed electrician will repair the two electrical receptacles in the wall mounted outlet box installed under the window in resident sleeping room 216 to have grounding protection to meet set standards by 5/23/2025. The Administrator or designee will have verified the work on 5/31/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. Maintenance Supervisor checked all other areas and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a The Administrator or designee will have inserviced the Maintenance Supervisor/designee	05/23/2025

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WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

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	cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect two residents and staff. Findings include: Based on observations with the Interim Administrator and the Maintenance Director at 2:02 p.m. on 04/21/25, two of the two electrical receptacles in the wall mounted outlet box installed under the window in resident sleeping Room 216 were found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on observations with the Interim Administrator and the Maintenance Director at 2:38 p.m. on 04/21/25, two of the two electrical receptacles in the wall mounted outlet box installed under the window in resident sleeping Room 101 were also found to have an "open ground" when tested with the Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the testing device showed the aforementioned electrical receptacle locations needed repair. These findings were not reviewed with the Interim Administrator and the Maintenance Director during the exit conference.		on the requirement to ensure the receptacle outlets have grounding protection in all resident areas to meet set standards by 5/8/2025. b Maintenance Supervisor/designee will ensure the receptacle outlets have grounding protection in all resident areas as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (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	

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	3.1-19(b)		compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/23/2025.**	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on record review, observation and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states that each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states that full unobstructed access to the fire damper shall be verified and corrected as required. This deficient	K 0521	**K521** – It is the intent of the facility to ensure all fire dampers in the facility are inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a The facility's licensed HVAC contractor will have conducted the four-year fire damper inspection for fire dampers installed in the HVAC system including the vent in the ceiling in the corridor outside resident sleeping room 201 and documented the results in the life safety binder to meet set standards by 5/23/2025. The Administrator or designee will have verified the work by 5/23/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a The Administrator or	05/23/2025

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	practice could affect all residents, staff and visitors. Findings include: Based on record review with the Interim Administrator and the Maintenance Director at 1:10 p.m. on 04/21/25, fire damper inspection and maintenance documentation within the most recent four year period was not available for review. Based on interview at 1:10 p.m. on 04/21/25, the Maintenance Director agreed that fire damper inspection and maintenance documentation within the most recent four year period was not available for review. Based on observations at 1:40 p.m. on 04/21/25, a fire damper was installed in an HVAC vent in the ceiling in the corridor outside resident sleeping Room 201. No inspection and testing documentation was affixed to this damper location. Based on interview at 1:40 p.m. on 04/21/25, the Maintenance Director stated fire dampers were located throughout the facility and agreed it could not be ensured fire dampers in the facility were inspected and tested within the most recent four year period. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		designee will have inserviced the Maintenance Supervisor/designee on the requirement to conduct the four-year fusible link fire damper inspection for fire dampers installed in the HVAC system and document the results in the Life Safety Binder by 5/8/2025. b the Maintenance Supervisor/designee will ensure to conduct the four-year fusible link fire damper inspection for fire dampers installed in the HVAC system as a part of the facilities Preventive Maintenance Program and document those inspection results as appropriate. All staff will be inserviced annually or as needed. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			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 5/23/2025.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Interim Administrator and the Maintenance Director at 12:00 p.m. on 04/21/25, documentation for the fire drill conducted on 05/07/24 at 7:00 p.m. during the second quarter (April, May, June) 2024 indicated the drill was a second shift fire drill conducted	K 0712	**K712** –It is the intent of the facility to ensure to document activation of the fire alarm system on fire drills conducted between 6:00 am and 9:00 pm on the second shift for all 4 quarters to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a The Maintenance Supervisor will have conducted a fire drill on second shift and included documentation for the activation of the fire alarm system and transmission of the fire alarm signal to meet set standards by 5/23/2025. The Administrator or designee will have verified the work by 5/23/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to	05/23/2025

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	after 6:00 a.m. but before 9:00 p.m. which did not document activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned second shift fire drill documentation stated "silent fire drill" in Section 1.g of the documentation. Based on interview at 12:00 p.m. on 04/21/25, the Interim Administrator and the Maintenance Director stated the 05/07/24 fire drill was a second shift fire drill, the facility operates three shifts per day and agreed the 05/07/24 second shift fire drill conducted at 7:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a By 5/8/2025 the Administrator or designee will have inserviced the Maintenance Supervisor on the requirement to ensure fire drills are conducted at the correct time and include activation of the fire alarm system and transmission of the fire alarm signal to meet set standards. b Maintenance Supervisor/Administrator/designee will ensure fire drills are conducted at the correct time and include activation of the fire alarm system and transmission of the fire alarm signal as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and	

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			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 5/23/2025.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review, observation and interview; the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and	K 0918	**K918** - It is the intent of the facility to ensure to exercise the emergency generators annually to meet the requirements of NFPA 110, 2010 edition, the Standard for Emergency and Standby Powers Systems, chapter 8.4.2 and to document 36 month period emergency generator testing in accordance with NFPA 99 & NFPA 110 and to ensure automatic transfer switches is maintained in accordance with NFPA 110 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: A The Maintenance Supervisor/designee will ensure the monthly load testing achieves	05/23/2025

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	shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Monthly Test Log" documentation with the Interim Administrator and the Maintenance Director at 1:10 p.m. on 04/21/25, monthly load testing documentation for the facility's diesel-fuel fired emergency generator for the six month period of July 2024 through December 2024 indicated the load test achieved was 29% which was less than 30 percent of the EPS name plate rating. Based on interview at 1:10 p.m. on 04/21/25, the Maintenance Director stated the facility has corrected how they calculate the load percentage achieved for monthly load testing conducted since January 2025, monthly load testing now achieves greater than 30% load but agreed annual supplemental load (load bank testing) documentation for the most recent twelve month period was not available for review. Based on observations with the Interim Administrator and the Maintenance Director at 2:51 p.m. on 04/21/25, the facility has one diesel-fuel fired emergency generator located outside the facility on the southwest side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 157 kW. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference.		greater than 30% load for all future testing to meet set standards by 5/23/2025. The Administrator or designee will have verified the work by 5/23/2025. B The Maintenance Supervisor/designee will have conducted the thirty-six-month period emergency generator testing for four hours and documented the results in the Life Safety Binder to meet set standards by 5/23/2025. The Administrator or designee will have verified the work by 5/23/2025. C The facility's certified generator contractor/ Maintenance Supervisor will have repaired the automatic transfer switch in the housekeeping room to ensure the position indicator is illuminated to meet set standards by 5/23/2025. The Administrator or designee will have verified the work by 5/23/2025. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: 1.The Administrator or designee will inservice the Maintenance Supervisor/designee on the requirement to ensure to conduct proper maintenance and testing of the emergency generator including conducting the monthly load testing with a load	

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	3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Interim Administrator and the Maintenance Director at 1:10 p.m. on 04/21/25, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel-fuel fired emergency generator was not available for review. Based on interview at 1:10 p.m. on 04/21/25, the Maintenance Director stated the facility has one diesel-fuel fired emergency generator and agreed documentation of supplemental load testing for		greater than 30%, ensure thirty six month testing for four hours is conducted and ensure the position indicators illuminate on the automatic transfer switch to meet set standards by 5/8/2025. b The Maintenance Supervisor will ensure to conduct proper maintenance and testing of the emergency generator including conducting the monthly load testing with a load greater than 30%, ensure thirty-six month testing for four hours is conducted and ensure the position indicators illuminate on the automatic transfer switch as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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	four hours within the most recent three year period was not available for review. Based on observations with the Interim Administrator and the Maintenance Director at 2:51 p.m. on 04/21/25, the facility has one diesel-fuel fired emergency generator located outside the facility on the southwest side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 157 kW. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 3 automatic transfer switches was maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, Section 6.2.16.2 states two pilot lights with identification nameplates or other approved position indicators shall be provided to indicate the switch position. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Interim Administrator and the Maintenance Director at 2:44 p.m. on 04/21/25, neither position indicator for the automatic transfer switch identified as "ATS #1" in the housekeeping room was illuminated to indicate the switch position. Based on interview at the time of the observations, the Maintenance Director stated the automatic transfer switch is operable but agreed neither position indicator for ATS #1 was illuminated to indicate the switch position.		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 5/23/2025.**	

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	These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances	K 0921	**K921** – It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.By 5/23/2025 the facility's trained Regional Property Managers will conduct PCREE testing on the other PCREE in the facility including: electric beds, nebulizers, oxygen concentrators, vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator or designee will have verified the work by 5/23/2025 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.By 5/8/2025 the Administrator will have inserviced the Maintenance	05/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155571	A. BUILDING 01 B. WING	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

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	receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Interim Administrator and the Maintenance Director at 1:10 p.m. on 04/17/25, PCREE testing documentation was not available for review. Based on interview at 1:10 p.m. on 04/17/25, the Maintenance Director agreed PCREE testing documentation was not available for review. Based on observations with the Interim Administrator and the Maintenance Director at 2:10 p.m. on 04/17/25, the resident bed in Room 111 nearest the corridor door was an electric bed. The resident bed in Room 115 was also an electric bed. An oxygen concentrator and a CPAP machine were also stored in the room. These findings were reviewed with the Interim Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Supervisor/DON/designee to ensure the testing of the PCREE is conducted and documented on all PCREE equipment to meet set standards. 2.Maintenance Supervisor/designee will ensure testing of the PCREE is conducted and documented on all PCREE equipment as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (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	

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			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 5/23/2025.**	