PRINTED: 08/31/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. I		A. BU	MULTIPLE CONSTRUCTION BUILDING WING		(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	HE	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573			
(X4) ID PREFIX TAG E 0000 Bldg	An Emergency Pre conducted by the In accordance with 42 Survey Date: 02/28 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Waters of Wakarus found in compliant Preparedness Requ Medicaid Participa CFR 483.73 The facility has 13 certified for Medic certified for Medic survey, the census	paredness Survey was adiana Department of Health in 2 CFR 483.73. 26723 27824 28725 2986 Preparedness survey, The sa Skilled Nursing Facility was see with Emergency irements for Medicare and ting Providers and Suppliers, 42 3 certified beds. 109 are dually are and Medicaid; 24 are are only. At the time of the	E 00	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 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 complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wifederal Medicaid requirements. Plea consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified the survey.	t the set red ce n on ith se	(X5) COMPLETION DATE
K 0000					We respectfully request a par review for compliance.		
Bldg. 01	Licensure Survey v	e Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0	000	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		

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

TITLE

(X6) DATE

James Schmidt Administrator 03/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155582	B. W	ING		02/28/	2023
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	=	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Wakarusa Skilled Nin compliance with in Medicare/Medica Safety from Fire and National Fire Protect Life Safety Code (Life Safety Code). This one story facility Type V (000) constructions by the same of the corridor provided with batter The facility is partial diesel-powered 230 facility has 133 cert certified for Medica.	Code survey, The Waters of fursing Facility was found not Requirements for Participation and, 42 CFR 483.90(a), Life d the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies. At was determined to be of ruction and was fully cility has a fire alarm system on in the corridors and in areas as 73 resident rooms were ry operated smoke detectors. Ally protected by a kW emergency generator. The iffied beds. 109 are dually are and Medicaid; 24 are are only. At the time of the was 88.			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 Federal Medicare and Medicaid requirements. Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified the survey. We respectfully request a paper eview for compliance.	red ce on th	
K 0211 SS=E	NFPA 101 Means of Egress -						
Bldg. 01	in accordance with of egress is contin all obstructions to	ays, corridors, exit cations, and accesses are n Chapter 7, and the means accessly maintained free of full use in case of s modified by 18/19.2.2					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155582	B. W	NG		02/28/	/2023	
		10000			_	02,20,		
NAME OF F	PROVIDER OR SUPPLIEF	8		STREET ADDRESS, CITY, STATE, ZIP COD				
01 1	NO VIDEN ON BOTTELL			300 N WASHINGTON ST				
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, T	ΗE	WAKARUSA, IN 46573				
(X4) ID	SHWWADV	STATEMENT OF DEFICIENCIE	I	ID			(Y5)	
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	+		DATE	
		ation and interview, the facility	K 0	211	DISCLAIMER STATEMENT:		03/20/2023	
		f 1 exit doors from the kitchen			Preparation and/or execution	1		
	and beauty shop on	ly contained one latching			of this plan of correction in			
	mechanism to relea	se the door and open. LSC			general, or this corrective			
	7.2.1.5.10 states a la	atch or other fastening device			action in particular, does not	t		
	on a door leaf shall	be provided with a releasing			constitute an admission or			
	device that has an o	obvious method of operation			agreement by this facility of	the		
		operated under all lighting			facts alleged or conclusions			
		.10.4 states the releasing			forth in this statement of			
		pen the door leaf with not more			deficiencies. The plan of			
	-	operation. 7.2.1.5.10.1 states		correction and specific				
	the releasing mechanism for any latch shall be				corrective actions are prepar	red		
	located not less than 34 inches, and not more than				and/or executed in complian			
	48 inches, above the finished floor. This deficient				with state and federal laws.	CC .		
	practice could affect staff and residents that use							
	the kitchen and bea				This plan of correction			
	the kitchen and bea	atty snop.			constitutes a written allegati			
	Ti., 4i., i., .1., 4				of substantial compliance wi	un		
	Findings include:				Federal Medicare and			
	D 1 1 2	tot of the first			Medicaid requirements. Plea	se		
		on with the Maintenance			consider allowing paper			
		tive Director on 02/28/23			submission of audits and			
	-	and 3:40 p.m., one door leading			education as evidence of			
		d one leading into the			compliance with the state and			
		ere equipped with two latching			federal requirements identified	d in		
		door push handle and a			the survey.			
	separate deadbolt lo	ock. Furthermore, the door			We respectfully request a par	oer		
		auty shop had a turn handle			review for compliance.			
	and separate deadbo	olt lock. Based on interview at			K211 – It is the intent of the			
	the time of observa	tions, the Maintenance			facility to ensure exit doors on	ly		
	Director agreed the	three doors had two separate			contain one latching mechanis	sm		
	latching mechanism	ns.			to release the door and open a	and		
					means of egress are continuo			
	This finding was re	eviewed with the Maintenance			maintained free of all obstruct			
		tive Director during the exit			or impediments to full instant u			
	conference.	S			in the case of fire or other			
					emergency to meet set standa	ards.		
	3.1-19(b)				1. CORRECTIVE ACTION			
					TAKEN:	-		
	2. Based on observa	ation and interview, the facility			a. On 3-17-23 the			
			1		S.		1	

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failed to ensure 1 of 7 means of egress were

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Maintenance Supervisor/designee

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	R MEDICARE & MEDIC						IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ALILTIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ	BUILDING	01	COMPI	
THILD TELLI	or conduction	155582		VING	01	02/28	
		100002	Б. ,			02/20	72020
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
THIND OF	ing (ibbit off boll bib)			300 N \	WASHINGTON ST		
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE	WAKAI	RUSA, IN 46573		
(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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	continuously maint	ained free of all obstructions			removed one of the latching		
	or impediments to i	full instant use in the case of			mechanisms from the door le	ading	
		ency. This deficient practice			into the kitchen and the one		
	could affect all staf	f and residents in the Rose Pod			leading into the dishwasher a	rea	
	hall				and the door leading into the		
					beauty shop to meet set		
	Findings include:				standards. The Administrator	r	
					verified the work on 3-17-23.		
	Based on an observ	vation during a tour of the			b. On 3-1-23 the Maintena	ance	
	facility with the Ma	aintenance Director and			Supervisor/designee removed	d the	
	Executive Director	on 02/28/23 between 1:20 p.m.			cart from the Rose pod hall e	xit	
	and 3:40 p.m., the I	Rose Pod hall exit corridor			corridor to meet set standards	S.	
	contained a lost & t	found clothing cart stored in			The Administrator verified the	work	
	the corridor. Based	on an interview at the time of			on 3-1-23 .		
	observations, the E	xecutive Director stated that			2. ALL OTHERS WITH		
	the cart is stored the	ere permanently. The			POTENTIAL TO BE AFFECT	ED:	
	Executive Director	moved the cart out of the			a. All residents and all sta	ıff	
	corridor upon obser	rvation.			and visitors have the potentia	l to	
					be affected but none were. C)n	
	The findings were i	reviewed with the Executive			3-1-23 the Maintenance		
	Director and the Ma	aintenance Director during the			Supervisor/designee inspecte	ed all	
	exit conference.				corridor means of egress and		
					found no other negative findir	ngs.	
	3.1-19(b)				3. MEASURES TO PREV	ENT	
					REOCCURRENCE:		
					a. On 3-13-23 the		
					Administrator Inserviced the		
					Maintenance Supervisor/desi	gnee	
					and all other staff on the		
					requirement that exit doors or	าly	
					contain one latching mechani	sm	
					to release the door and the		
					corridor means of egress are	to	
					remain free of obstructions to		
					meet set standards.		
					b. Maintenance		
					Supervisor/designee will ensu	ıre	

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the exit doors only contain one latching mechanism to release the door and will inspect all corridor

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/28/2023
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				means of egress throughout of facility weekly for obstructions a part of the facility's Prevention Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/desi will review with the Administration 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 Administrator will present the inspection results and supervisor/designee to the Administrator will present the inspection results at the mont Quality Assurance/Performan 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is	s as ive esults s are essed he gnee ator will ance e thly ace g. h by an

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Facility ID: 000521

3-20-23.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED	
		155582	B. WI	NG		02/28/	/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	₹			WASHINGTON ST			
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	Ε	WAKARUSA, IN 46573				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DLANLOF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.1E	DATE	
K 0293	NFPA 101							
SS=D	Exit Signage							
Bldg. 01	Exit Signage							
Diag. 01	2012 EXISTING							
		al signs are displayed in						
		7.10 with continuous						
		erved by the emergency						
	lighting system.	c. tod by the officingency						
	19.2.10.1							
	(Indicate N/A in or	ne-story existing						
		less than 30 occupants						
	•	exit travel is obvious.)						
	Based on record review and interview; the facility		K 02	293	K293– It is the intent of the fac	cility	03/20/2023	
		signage in 1 of 2 corridors in	10.	273	to ensure to provide and main	•	03/20/2023	
		dance with LSC 7.10. LSC			exit signage in corridors in the			
		ner than main exterior exit doors			kitchen in accordance with LS			
		clearly are identifiable as exits,			7.10 to meet set standards.	ŭ		
	-	an approved sign that is			1. CORRECTIVE ACTION	IS		
	-	any direction of exit access.			TAKEN:			
		es horizontal components of the			a. On 3-15-23 the			
		an exit enclosure shall be			Maintenance Supervisor/design	anee		
		d exit or directional exit signs			repaired the exit sign in the	,		
		tion of the egress path is not			kitchen to meet set standards			
		ient practice could affect staff			The Administrator verified the	work		
	and at least 5 kitche	en staff.			on 3-16-23.			
					2. ALL OTHERS WITH			
	Findings include:				POTENTIAL TO BE AFFECTI	ED:		
					a. All residents and all sta	ff		
	Based on observation	on with the Executive Director			and visitors have the potential	to		
	and Maintenance D	irector on 02/28/23 between			be affected but none were.			
	1:20 p.m. and 3:40	p.m., the exit sign in the kitchen			3. MEASURES TO PREVI	ENT		
	_	ea indicates occupants to			REOCCURRENCE:			
		s the dishwashing area. On			a. On 3-13-23 the			
	observation, the dis	hwasher area had no			Administrator in serviced the			
	emergency exit. Ba	sed on interview at the time of			Maintenance Supervisor/desig	gnee		
	observation, the Ex	ecutive Director acknowledged			on the requirement to ensure	to		
		condition and confirmed that			provide and maintain exit and			
	the path of egress w	vas not obvious.			directional exit signs to mark e	exit		
					paths to reach the exits to me	et		
	This finding was re	viewed with the Executive			set standards.			

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTII A. BUILDI B. WING	PLE CONSTRU NG <u>01</u>			(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	30		ss, city, state, zip cod INGTON ST IN 46573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREI TA	FIX CRO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
		enance Director at the exit		b. Supo mon exit: inspection insp	Maintenance ervisor/designee will conditate the section results on the ergency Lights & Signs Teas a part of the facility's rentive Maintenance gram. If any issues are overed, they will be addressed with the Administrator will itor adherence to the rentative Maintenance entative Maintenance and validate the rentative Maintenance entative en	est essed he gnee ator will ance e thly ice g. i by on		

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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	COMPL	LETED
		155582	B. WI	NG		02/28/	/2023
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0300 SS=F	NFPA 101 Protection - Other				all regulatory requirements. Our date of compliance is 3-20-23.		
Bldg. 01	Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included Based on record revolved by the fact documentation for the public, if not maintained. NFPA Tests. Fire-warning and tested in according published instruction of Chapter 14. NFPA testing, and mainter the requirements of equipment manufact This deficient practice staff, and visitors. Findings include: Based on records represent the process of the fact of the	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.	K 0.	300	K300– It is the intent of the fact to ensure documentation for the preventative maintenance of battery operated smoke alarm resident rooms is complete to meet set standards. 1) CORRECTIVE ACTIONS TAKEN: a) On 3-1-23 the Maintena Supervisor/designee removed the battery-operated smoke all batteries and replaced them where the potential of the battery operated smoke all battery operated smoke all battery operated smoke all documented the installation or battery operated smoke alarm and documented on the Battery-Operated Smoke Determined the installation on 3-2-23. 2) ALL OTHERS WITH POTENTIAL TO BE AFFECTE a) All residents and all state and visitors have the potential	he sin Sance I all larm with ries In the las	03/20/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	300 N	r address, city, state, zip cod I WASHINGTON ST ARUSA, IN 46573	
(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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OF cleanings, but did n which batteries wer detectors. At interview Maintenance Direct when the batteries when the b	ot document the times at e replaced in the smoke iew during record review, the tor stated they do not know were changed last and should		be affected but none were. 3) MEASURES TO PREVERECCURRENCE: a) On 3-13-23 the Administrator inserviced the Maintenance Supervisor/desi on the requirement that batter operated smoke alarms must maintained including the batter replacement dates and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will ensumaintain the battery smoke alarms including the battery replacements per manufactur guidelines throughout the fact and document the results on Battery-Operated Smoke Det Maintenance Log to be filed in Life Safety Binder as a part of facility's Preventive Maintenane Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designed will review with the Administrative 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 to be presented by the Maintenance Supervisor/designee to the	gnee ry be erry e ure to er's lity the ector n the f the nce essed ne gnee ator

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/28/2023
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation 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	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.		Administrator will present the inspection results at the monoguality Assurance/Performate Improvement (QA/PI) meetides Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensurcompliance is maintained. This plan of correction constitutes our credible allegation of compliance wall regulatory requirements. Our date of compliance is 3-20-23.	nthly ance ng. em d by tion d as re

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 02/28/2023 155582 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility K 0321 03/20/2023 **K321**– It is the intent of the facility failed to ensure the corridor doors to 1 of 1 utility to ensure the corridor doors to storage rooms which is a hazardous area utility storage rooms which is a containing combustible storage and greater than hazardous area containing 50 square feet was provided with a self-closing combustible storage and greater device which would cause the door to than 50 square feet is provided automatically close and latch into the door frame. with a self-closing device which This deficient practice could over 10 staff and would cause the door to residents in one smoke compartment. automatically close and latch into the door frame to meet set Findings include: standards. 1. **CORRECTIVE ACTIONS** Based on observations during a tour of the facility TAKEN: with the Maintenance Director and Executive On 3-3-23 the Maintenance Director on 02/28/23 between 1:20 p.m. and 3:40 Supervisor/designee repaired the p.m., the utility storage room in Rose Pod, a self-closing device on the utility hazardous storage room that was greater than 50 storage room in Rose Pod so it square feet, was equipped with self-closing device latches into the frame to meet set but did not latch into the frame when tested three standards. The Administrator times. Based on interview at the time of verified the work on 3-13-23. observation, the Maintenance Director and 2. **ALL OTHERS WITH** Executive Director agreed the room was used as POTENTIAL TO BE AFFECTED: storage, was larger than 50 square feet, and stated All residents and all staff the self-closing hinges of the door need to be and visitors have the potential to adjusted in order for the door to latch into the be affected but none were. On

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frame. The door was able to latch after fixing the

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3-1-23 the Maintenance

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155582	B. WI	NG	02/28/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	E		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	latch during observ	vation.			Supervisor/designee inspecte		
					hazardous areas for self-closi	ng	
		cussed with the Executive			devices and found no other		
		tenance Director at exit			negative findings.		
	conference.				3. MEASURES TO PREVE	ENT	
	2.1.10(%)				REOCCURRENCE:		
	3.1-19(b)				a. On 3-13-23 the		
					Administrator in serviced the Maintenance Supervisor/design	nnee	
					on the requirement that all	J. ICC	
					hazardous areas have self-clo	sina	
					devices and self-close and lat	-	
					fully into the frame to meet se		
					standards.	•	
					b. Maintenance		
					Supervisor/designee will inspe	ect	
					all hazardous area doors		
					throughout the facility monthly	to	
					ensure they have self-closing		
					devices and self-close and lat	ch	
					fully into the frame as a part o	f the	
					facility's Preventive Maintenar	nce	
					Program and document those		
					inspection results as appropri		
					If any issues are discovered, t	-	
					will be addressed and resolve	-	
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					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 v	vill	
					be presented by the Maintena		
1			1		1 '		1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/28/2023
	PROVIDER OR SUPPLIEF	SKILLED NURSING FACILITY, TH	300 N \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartments comply with 3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under the cooking such as the cooking facilities with a cooking facilities with a cooking facilities with a cooking such as the cooking such as	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small as microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under		Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the more Quality Assurance/Performa Improvement (QA/PI) meetir Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correcting developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance we all regulatory requirements Our date of compliance is 3-20-23.	e nthly nnce ng. m d by son l as e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155582	B. W	NG		02/28/	/2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			WASHINGTON ST		
WATER	S OF WAKABIISA	SKILLED NURSING FACILITY, TH	=	1	RUSA, IN 46573		
WATER	OF WARARUSA	SKILLED NORSING FACILITY, TH		WARAI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	NFPA 96 per 9.2.	3 are not required to be					
	enclosed as haza	irdous areas, but shall not					
	be open to the corridor.						
	18.3.2.5.1 through	h 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.	5, 9.2.3, TIA 12-2					
	Based on observati	on and interview, the facility	K 0	324	K324- It is the intent of the fa	cility	03/20/2023
	failed to ensure sta	ff had access to the shutoff			to ensure staff has access to	ihe	
	switch for 1 of 1 co	ook tops in the activities room.			shutoff switch for cooktops in	the	
	LSC 19.3.2.5.4 stat	tes within a smoke compartment,			activities room to meet set		
	residential or comm	nercial cooking equipment that			standards.		
	is used to prepare r	neals for 30 or fewer persons			1. CORRECTIVE ACTIONS		
	shall be permitted,	provided that the cooking			TAKEN:		
	facility complies w	rith all of the following			a. On 3-2-23 the Maintenance	Э	
	conditions:				Supervisor/designee replaced	the	
	(1) The space conta	aining the cooking equipment			lock on the cooktop in the		
	is not a sleeping ro	om.			activities room to meet set		
		aining the cooking equipment			standards. The Administrator		
	_	from the corridor by partitions			verified the work on 3-2-23.		
		.3.6.2 through 19.3.6.5.			2. ALL OTHERS WITH		
	(3) The requirement	nts of 19.3.2.5.3(1) through (10)			POTENTIAL TO BE AFFECTI	ED:	
	and (13) are met.				a. All residents and all staff a	nd	
		A switch meeting all of the			visitors have the potential to b	е	
	following is provid				affected but none were.		
		n, or a switch located in a			3. MEASURES TO PREVENT		
		is provided within the cooking			REOCCURRENCE:		
	-	rates the cooktop or range.			a. On 3-13-23 the Administr	ator	
		sed to deactivate the cooktop			in serviced the Maintenance		
	_	the kitchen is not under staff			Supervisor/designee on the		
	supervision.				requirement that all staff has		
	_	tice could affect five residents			access to the shutoff switch for	•	
	in the therapy gym	•			cooktops to meet set standard	ls.	
					b. Maintenance		
	Findings include:				Supervisor/designee will ensu		
					staff has access to the shutoff	•	
		on with the Maintenance			switch for cooktops as		
		ntive Director on 02/28/23			appropriate. If any issues are		
		and 3:40 p.m., there was a			discovered, they will be addre		
	_	vities room that was separated			and resolved immediately. Th		
		hat had a shut off, but was not			Maintenance Supervisor/design	-	
	locked or restricted	I from unauthorized access.			will review with the Administra	itor	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155582	A. BU B. WI		01	COMPL 02/28/	
		100002	B. WI			02/20/	2020
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	łΕ		WASHINGTON ST RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		at the time of observation, the			the inspection results.	:4	
		or was unable to secure the ey will need to switch the			c. The Administrator will monitative adherence to the Preventative		
	lock.	ley will need to switch the			Maintenance schedule and	;	
	lock.				validate the Preventative		
	The finding was rev	viewed with Maintenance			Maintenance documentation is	s in	
	Director and Executive Director during the exit				place.		
	conference.	-			4. MONITORING CORRECTIV	/E	
					ACTION:		
	3.1-19(b)				a. The inspection results will b		
					presented by the Maintenance)	
					Supervisor/designee to the		
					Administrator monthly and the	:	
					Administrator will present the inspection results at the month	bly	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed l		
					the QA/PI Committee with	,	
					subsequent plans of correction	n	
					developed and implemented a	IS	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible allegation of compliance with	h	
					all regulatory requirements.	1	
					Our date of compliance is		
					3-20-23.		
						İ	
K 0341	NFPA 101						
SS=F	Fire Alarm System						
Bldg. 01	Fire Alarm System						
		m is installed with systems					
		approved for the purpose in NFPA 70, National Electric					
		72, National Fire Alarm					
		ffective warning of fire in any					
	-	a. In areas not continuously					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155582	B. WI	NG		02/28/2023
			_	STREET	ADDRESS, CITY, STATE, ZIP COD	<u>. </u>
NAME (OF PROVIDER OR SUPPLIE	R			WASHINGTON ST	
WATE	RS OF WAKARUSA	SKILLED NURSING FACILITY, T	HE		RUSA, IN 46573	
(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	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	occupied, detection	on is installed at each fire				
	alarm control unit	. In new occupancy,				
	detection is also i	nstalled at notification				
	appliance circuit power extenders, and					
		n transmitting equipment.				
	Fire alarm system	-				
	· ·	s are monitored for				
	integrity.					
	18.3.4.1, 19.3.4.1					
		on and interview, the facility	K 03	341	K341 – It is the intent of the	03/20/2023
	 	of 1 fire alarm systems was			facility to ensure fire alarm	
		ance with 19.3.4.1. LSC 9.6.1.3			systems are installed in	
	-	n system to be installed, tested,			accordance with 19.3.4.1 to m	neet
		accordance with NFPA 70,			set standards.	
		Code and NFPA 72, National			1. CORRECTIVE ACTION	S
		NFPA 72, 17.7.4.1 requires in			TAKEN:	
		r handling systems, detectors			a. On 3-13-23 the Certified	d
		l where air flow prevents			Contractor/Maintenance	
	1 -	tectors. This deficient practice			Supervisor/designee moved the	ne
	could affect 20 in o	one smoke compartment.			smoke detector to meet set	
					standards. The Administrator	
	Findings include:				verified the work on 3-13-23.	
		tal at the tra			2. ALL OTHERS WITH	
		on with the Maintenance			POTENTIAL TO BE AFFECTI	
		ntive Director on 02/28/23			a. All residents and all sta	
	_	and 3:40 p.m., in the kitchen			and visitors have the potential	
	-	ne dish cleaning area, there was			be affected but none were. O	n
		ext to an air return where air			3-1-23 the Maintenance	ال ما
	•	t proper operation of the tor was a about 20 inches from			Supervisor/designee inspecte	
		interview at the time of			other areas and found no other	#
					negative findings.	ENT
	 	s in the direct airflow from the			3. MEASURES TO PREVI	IN I
		hin 20 inches of the vent.			REOCCURRENCE:	
	return and was With	mm 20 menes of the vent.			a. On 3-13-23 the	
	This finding was	vioused with the Everetive			Administrator in serviced the	3000
	_	eviewed with the Executive			Maintenance Supervisor/desig	Juee
		tenance Director during the exit			and all other staff on the	.
	conference.				requirement fire alarm system	
	3.1-19(b)				are installed in accordance wi	
	L 3.1-19(D)		1		19 3 4 1 to meet set standards	s 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155582	A. BUILDING B. WING	01	COMPLETED 02/28/2023			
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TI	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST Y, THE WAKARUSA, IN 46573					
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				b. Maintenance Supervisor/designee will inspall fire alarm systems monthly ensure they are in accordance with 19.3.4.1 as a part of the facility's Preventive Maintenane Program and document those inspection results as appropriated any issues are discovered, will be addressed and resolve immediately. The Maintenane 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 to be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented adeemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allocation of compliance with subsequent with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of compliance with subsequent plans of correction constitutes our credible allocation of correc	vito e nce e ate. they ed ce ew will ance e hly ce g. n by n as			

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CENTERDIO	WIEDICHNE & MEDIC	THE SERVICES			OHID 110. 0700 007
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155582	B. WING		02/28/2023
		1			
NAME OF 1	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD	
				WASHINGTON ST	
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE WAKA	RUSA, IN 46573	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINEDS DEAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATI	DATE
				all regulatory requirements.	
				Our date of compliance is	
				3-20-23.	
				0 20 20.	
K 0345	NFPA 101				
SS=F	Fire Alarm Systen	n - Testing and			
Bldg. 01	Maintenance	3			
ū	Fire Alarm Systen	n - Testing and			
	Maintenance	ŭ			
	A fire alarm syste	m is tested and maintained			
		h an approved program			
		e requirements of NFPA 70,			
		Code, and NFPA 72,			
		m and Signaling Code.			
		n acceptance, maintenance			
	and testing are re				
		IFPA 70, NFPA 72			
		review and interview, the	K 0345	K345– It is the intent of the faci	03/20/2023
		sure all pull stations for 1 of 1	1 0545	to ensure all pull stations and	03/20/2023
	1	were inspected, tested, and		sensitivity on smoke detectors	for
	1	rdance with NFPA 72, National		fire alarm systems are inspecte	
		FPA 72 Table Testing		tested and maintained in	α,
		15(7)(m) requires water flow		accordance with NFPA 72,	
	_	eted and tested annually. This		National Fire Alarm Code and t	
	_	ould affect all occupants.		ensure fire alarm systems are	
				maintained in accordance with	
	Findings include:			LSC 9.6.1.3 to meet set	
				standards.	
	Based on record rev	view with the Maintenance		1. CORRECTIVE ACTIONS	<u>;</u>
		23 at 10:50 a.m., the annual fire		TAKEN:	,
		07/14/22 indicated "Rose Pod"		a. On 3-10-23 a Certified Fi	ire
	_	tested "due to COVID". The		Alarm Contractor/designee	
	_	inspection later dated 1/21/23,		conducted the semiannual visu	al
		visually inspected, but was		inspection of the fire alarm syst	
	_	d." It was unable to be		including pull stations and retai	
	-	r the pull station passed or		documentation in the facilities L	
		ased on interview at the time of		Safety Binder to meet set	
	•	Maintenance Director agreed		standards. The Administrator	
		not tested within the last year,		verified the work on 3-13-23.	
	I P Station Was	uic iabe jeai,	1	1 . 5. 110 d ti 0 ti 0 10 20.	1

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and stated SafeCare will be contacted and should

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b.

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On 3-10-23 a Certified Fire

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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
		155582	B. WI	NG		02/28	/2023
			<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WASHINGTON ST		
WATERS	S OF WAKARIISA 9	SKILLED NURSING FACILITY, THE	=		RUSA, IN 46573		
WAILING		SKILLED NORSING FACILITY, THE		WAIXAI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nt set up within the end of the			Alarm Contractor/designee		
	day for inspection.				conducted the sensitivity test		
					the smoke detectors and retai		
	_	viewed with the Executive			documentation in the facilities	Life	
		enance Director at the exit			Safety Binder to meet set		
	conference.				standards. The Administrator		
	3.1-19(b)				verified the work on 3-13-23.		
					2. ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTE		
	2. Based on record review and interview, the				a. All residents and all stat		
	1	sure 1 of 1 fire alarm systems			and visitors have the potential	to	
		accordance with LSC 9.6.1.3.			be affected but none were.		
		es a fire alarm system to be			3. MEASURES TO PREVE	ENT	
		d maintained in accordance			REOCCURRENCE:		
		tional Electrical Code and NFPA			a. On 3-13-23 the		
		larm Code. NFPA 72, Section			Administrator in serviced the		
		otherwise permitted by other			Maintenance Supervisor/desig	gnee	
		de, testing shall be performed			on the requirement that	,	
		the schedules in Table 14.4.5,			semi-annual visual inspections		
		uired by the authority having			the fire alarm system must be		
	l -	72, Section 14.4.5.3.1 states			conducted to meet set standa	ras.	
		sitivity shall be checked within tion. NFPA 72, 14.4.5.3.2 states			b. Maintenance		
	l •	sitivity shall be checked every			Supervisor/designee will ensu		
		after unless otherwise			semi-annual visual inspections the fire alarm system is condu		
	1	liance with Section 14.4.5.3.3.			as a part of the facility's Preve		
	1	rice could affect all occupants.			Maintenance Program and	HILIVE	
	This deficient pract	nee coura arreet air occupants.			document those inspection res	eulte	
	Findings include:				as appropriate. If any issues		
	1 manigo menae.				discovered, they will be addre		
	Based on record rev	view with the Maintenance			and resolved immediately. Th		
		23 between 9:50 a.m. and 1:14			Maintenance Supervisor/desig		
		test had been conducted on			will review with the Administra	-	
		cument titled "Smoke and Duct			the inspection results.		
		oke detectors were not			c. The Administrator will		
		"No access due to COVID."			monitor adherence to the		
		at the time of record review, the			Preventative Maintenance		
		tor stated they were unaware if			schedule and validate the		
		had completed the sensitivity			Preventative Maintenance		
		ining five detectors and would			documentation is in place.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		r í	LDING	nstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/28/2023		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE	300 N V	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	This finding was re-	y by the end of the day. viewed with the Executive enance Director at the exit			4. MONITORING CORRECTIVE ACTION: a. The inspection results be presented by the Maintens Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the moniquality Assurance/Performar Improvement (QA/PI) meeting. Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wire all regulatory requirements. Our date of compliance is 3-20-23.	ance e thly ace g. by on as	
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with North Inspection, Testing Water-based Fire Records of system inspection and test secure location and secure system inspection and test secure location are secure system.	<u>.</u>					

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

Event ID:

XH0321

Facility ID: 000521

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155582	B. WI	NG		02/28/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			WASHINGTON ST		
WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, THE	Ξ	l	RUSA, IN 46573		
(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 APPROPRIA	NTE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on observation failed to ensure 3 of area were not loade material in accordant 2011 edition, at 5.2 signs of leakage; she foreign materials, period shall be installed in up-right, pendent, of 5.2.1.1.2 any sprink the following shall be Corrosion (3) Physisthe glass bulb heat a Loading (6) Paintin sprinkler manufacture could affect all staff. Findings include: Based on observation with the Maintenant Director on 02/28/2 p.m. 3 sprinkler heat and in the laundry redirt build-up. Based observation, the Mathe aforementioned accumulation and legislating them after. Findings were discussed in the laundry redirection of the mathematic sprinkler heat and in the laundry redirection of the mathematic sprinkler heat and in the laundry redirection of the mathematic sprinkler heat and in the laundry redirection of the mathematic sprinkler heat and in the laundry redirection and legislation	RKS information on non-required or partial or system. In and NFPA 25 attion and interview, the facility of 5 sprinkler heads in laundry dor covered with foreign nee with LSC 9.7.5. NFPA 25, 1.1.1 sprinklers shall not show all be free of corrosion, aint, and physical damage; and the correct orientation (e.g., or sidewall). Furthermore, at the that shows signs of any of the replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in responsive element (5) g unless painted by the arer. This deficient practice of near the laundry area The during a tour of the facility on the during a tour of the facility of the precion showed heavy lint and the on interview at the time of the time and would start to adding and would start	K 02		K353 – It is the intent of the facility to ensure sprinkler hear in the laundry area are not load or covered with foreign materiaccordance with LSC 9.7.5 and ensure to maintain sprinkler system in accordance with 19.3.5.3 to meet set standards. 1.CORRECTIVE ACTIONS TAKEN: 1.On 3-1-23 the Maintent Supervisor/designee cleaned three sprinkler heads located behind the dryer and in the lauroom to meet set standards. Administrator verified the work 3-1-23. 2.On 3-10-23 the Maintenance Supervisor/designee cleaned three sprinkler heads located behind the dryer and in the lauroom to meet set standards. Administrator verified the work 3-1-23. 2.On 3-10-23 the Maintenance Supervisor/designee confirmed that a certified spring confirmed that a certified sp	aded ial in and to s. ance the undry The k on gnee ankler ankler ife ort.	03/20/2023

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155582	B. W	ING		02/28/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			VASHINGTON ST		
\\\\\TEDG	C OE WAKADIISA	SKILLED NURSING FACILITY, THE	=		RUSA, IN 46573		
WATERS	OF WARARUSA	SKILLED NORSING FACILITY, THE		WARAI	103A, IN 40373		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		review and interview, the			1.On 3-13-23 the		
		aintain 1 of 1 sprinkler system in			Administrator in serviced the		
		9.3.5.3. NFPA 25, 2011 Edition,			Maintenance Supervisor/desig	gnee	
	_	t as discussed in 14.2.1.1 and			on the requirement that the		
	14.2.1.4 an inspection of piping and branch line				sprinkler system must be prop	erly	
	conditions shall be conducted every 5 years by				maintained to meet set standa	ards.	
		connection at the end of one			2.Maintenance		
	1	ring a sprinkler toward the end			Supervisor/designee will ensu		
		for the purpose of inspecting			the sprinkler heads are not loa		
	_	foreign organic and inorganic			or covered with foreign materi	al	
		eient practice could affect all			and will ensure required		
	occupants.				inspections of the sprinkler		
					system are conducted as a pa		
	Findings include:				the facility's monthly Preventiv	/e	
					Maintenance Program and		
		view with the Maintenance			document those inspection re-		
		23 between 09:50 a.m. and 1:14			as appropriate. If any issues		
		inspection from 12/20/22 stated			discovered, they will be addre		
	_	was completed in 2019, but had			and resolved immediately. Th		
	_	mentation to state whether it			Maintenance Supervisor/desig	_	
	_	spection. Based on interview at			will review with the Administra	itor	
		review, the Maintenance			the inspection results.		
	_	t documentation could not be			3.The Administrator will		
	found and would co	ontact the sprinkler company.			monitor adherence to the		
					Preventative Maintenance		
		ussed with the Executive			schedule and validate the		
		enance Director at exit			Preventative Maintenance		
	conference.				documentation is in place.		
					4.MONITORING CORRECT	IVE	
	3.1-19(b)				ACTION:		
					1.The inspection results		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the	!	
					Administrator will present the	L.L.	
					inspection results at the month	•	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
	I		1		components will be reviewed	ρV	I

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	Ē	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(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)	ΤE	(X5) COMPLETION DATE
					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 3-20-23.	s	
K 0521 SS=F Bldg. 01	comply with 9.2 at accordance with the specifications. 18.5.2.1, 19.5.2.1, Based on record reversitied to ensure all the inspected and provice after the first year and every four years in the LSC 9.2.1 requires conditioning (HVA) equipment shall be Standard for the Instand Ventilating System Edition, Section 5.4 maintained in according for Fire Doors and ONFPA 80, 2010 Edit damper shall be test installation. Section inspection frequence for hospitals where If the damper is equipment in the section in the secti		K 0	521	K521 – It is the intent of the facility to ensure all fire dampe in the facility area inspected at provided necessary maintenar after the first year after installa and at least every four years in accordance with NFPA 90A to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: 1.On 3-20-23 a Certified Contractor/designee started the inspection of the smoke/fire dampers in the facility to meet standards; the inspection is scheduled and planned to be completed by March 24, 2023. The Administrator will verify the inspections were completed at will verify the documentation be	nd nce tition n S set set	03/28/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TI	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	damper shall not be way. All inspection documented, indica damper, date of insideficiencies discover have a space to indideficiencies were confected affect all residents are limited. Based on records respection for the facility was not avainterview at the time Maintenance Direction of the damper insidered the damper insidered were dampers inspection was 201 would contact the complete an inspection.	eview with the Maintenance 2 at 10:00 a.m., documentation of e smoke/fire dampers in the illable for review. Based on e of record review, the tor stated that they could not pection records, but knew s within the facility and the last 8; which was overdue and ontracted company to		1.ALL OTHERS WITH POTENTIAL TO BE AFFECTE 1.All residents and all sta and visitors have the potential be affected but none were. 2.MEASURES TO PREVENT REOCCURRENCE: 1.On 3-13-23 the Administrator inserviced the Maintenance Supervisor/design on the requirement that smoke dampers must be properly inspected and maintained to me set standards. 2.Maintenance Supervisor/designee will ensurate the smoke/fire dampers are properly inspected and maintained as a part of the facility's monther Preventive Maintenance Program document those inspection results as appropriate. If any issues are discovered, they with 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. 3.MONITORING CORRECTIACTION: 1.The inspection results were presented by the Maintenance and the presented by th	off to T gnee e/fire neet re sined nly ram n ill be se w

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Supervisor/designee to the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155582	B. WI	ING		02/28/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	E		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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 I	эу	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	ıs	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.	!1	
					Our date of compliance is		
					3-28-23.		
					0 20 20.		
K 0522	NFPA 101						
SS=D	HVAC - Any Heat	ting Device					
Bldg. 01	HVAC - Any Heat	_					
	Any heating device	ce, other than a central					
	heating plant, is d	lesigned and installed so					
	combustible mate	erials cannot be ignited by					
	device, and has a	a safety feature to stop fuel					
	and shut down ed	quipment if there is					
	excessive temper	ature or ignition failure. If					
	fuel fired, the dev						
	* is chimney or ve						
		nbustion from outside.					
		ombustion system separate					
	from occupied are	ea atmosphere.					
	19.5.2.2						
		on and interview, the facility	K 0	522	K522 – It is the intent of the		03/20/2023
		of 1 laundry rooms were			facility to ensure laundry room	ıS	
	1 ^	ke combustion air from the			are provided with intake		
		containing fuel fired equipment.			combustion air from the outsic	le for	
	_	tice could create an atmosphere			rooms containing fuel fired	_	
	rich with carbon m	onoxide which could cause	1		equipment to meet set standa	rds.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLE	ETED
		155582	B. WING			02/28/2023	
			' 	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			WASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	physical problems for all staff in the laundry room.				1.CORRECTIVE ACTIONS		
	Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive				TAKEN:		
					1.On 3-1-23 the Maintena		
					Supervisor/Laundry Departme		
					Employee/designee cleaned to fresh air intake to meet set	ne	
		3 between 1:20 p.m. and 3:40			standards. The Administrator		
		om had fuel-fired dryers with a			verified the work on 3-1-23 an		
	-	was covered with lint and dirt.			3-17-23.	u	
		not allow for fresh air to			2.ALL OTHERS WITH		
		e room. Based on an interview			POTENTIAL TO BE AFFECTE	-D.	
		vation, the Maintenance			1.All residents and all sta	I	
		intake was covered with lint			and visitors have the potential	I	
	and would need to b				be affected but none were.	10	
	una would nood to	se creamed.			3.MEASURES TO PREVEN	т	
	Findings were discu	ussed with the Maintenance			REOCCURRENCE:	•	
	_	tive Director at exit conference.			1.On 3-13-23 the		
					Administrator in serviced laun	drv	
	3.1-19(b)				staff, Maintenance	,	
					Supervisor/designee on the		
					requirement that the fresh air		
					intake must remain free of lint	and	
					dirt to meet set standards.		
					2.Maintenance		
					Supervisor/designee will ensu	re	
					the fresh air intake is free of li	I	
					and dirt as a part of the facility		
					monthly Preventive Maintenar		
					Program and document those		
					inspection results as appropria	ate.	
					If any issues are discovered, t	hey	
					will be addressed and resolve	d	
					immediately. The Maintenand	e	
					Supervisor/designee will revie	w	
					with the Administrator the		
					inspection results.		
				3.The Administrator will			
					monitor adherence to the		
					Preventative Maintenance		
			1		schedule and validate the		

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
				Preventative Maintenance documentation is in place. 4.MONITORING CORRECTIVACTION: 1.The inspection results we be presented by the Maintenant 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 3-20-23.	vill nce ly e	
K 0761 SS=E Bldg. 01						
	interview, the facili inspection and testi assemblies were co 19.1.1.4.1.1 commu fire barriers require permitted only in co by approved self-cl (See also Section 8	on, records review, and ty failed to ensure annual ng of 1 of 17 fire door mpleted in accordance of LSC unicating openings in dividing d by 19.1.1.4.1 shall be perridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table	K 0761	K761 – It is the intent of the facility to ensure annual inspect and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1. communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted or in corridors and shall be protect by approved self-closing fire do	1 y nly sted	

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8.3.4.2 shall be protected by approved, listed,

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assemblies to meet set

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			TED	
		155582	B. WI	NG		02/28/2	023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(OKULI ED NUIDOINO EACULITY TU	_		WASHINGTON ST		
WATERS	S OF WAKARUSA	SKILLED NURSING FACILITY, TH	E	WAKAF	RUSA, IN 46573		
(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 OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	labeled fire door as	ssemblies and fire window			standards.		
	assemblies and the	ir accompanying hardware,			1. CORRECTIVE ACTION	IS	
	including all frame	s, closing devices, anchorage,			TAKEN:		
	and sills in accorda	ince with the requirements of			a. On 3-2-23 the Maintena	ance	
	NFPA 80, Standard	d for Fire Doors and Other			Supervisor conducted the anr	nual	
	Opening Protective	es, except as otherwise			fire door inspection on the		
	specified in this Co	ode. NFPA 80 5.2.1 states fire			occupancy barrier between		
	door assemblies sh	all be inspected and tested not			assisted living and healthcare	and	
	less than annually,	and a written record of the			documented those inspection		
	inspection shall be	signed and kept for inspection			results on the Annual Door		
	by the AHJ. NFPA	80, 5.2.4.1 states fire door			Inspections log to meet set		
	assemblies shall be	visually inspected from both			standards. The Administrator	-	
	sides to assess the	overall condition of door			verified the inspections and		
	assembly. NFPA 8	0, 5.2.4.2 states as a minimum,			documentation on 3-15-23.		
	the following items	s shall be verified:			2. ALL OTHERS WITH		
	(1) No open holes	or breaks exist in surfaces of			POTENTIAL TO BE AFFECT	ED:	
	either the door or f	rame.			a. All residents and all sta	ff	
	(2) Glazing, vision	light frames, and glazing beads			and visitors have the potentia	I to	
	are intact and secur	rely fastened in place, if so			be affected but none were.		
	equipped.				3. MEASURES TO PREV	ENT	
	(3) The door, frame	e, hinges, hardware, and			REOCCURRENCE:		
	noncombustible the	reshold are secured, aligned,			a. On 3-13-23 the		
	and in working ord	er with no visible signs of			Administrator/corporate Prope	erty	
	damage.				Manager inserviced the		
	(4) No parts are mi	ssing or broken.			Maintenance Supervisor/design	gnee	
	` '	s do not exceed clearances			on the requirement that annua	al	
	listed in 4.8.4 and				testing & inspections of fire ra	ited	
	` '	g device is operational; that is,			doors must be conducted to		
		npletely closes when operated			ensure proper operation and		
	from the full open	-			documented on the Annual D	oor	
	(7) If a coordinator	is installed, the inactive leaf			Inspections log and maintaine	ed at	
	closes before the ac	ctive leaf.			the facility to meet set standa	rds.	
		vare operates and secures the			b. Maintenance		
	door when it is in t	-			Supervisor/designee will cond	duct	
	` '	vare items that interfere or			the annual door inspections to	o	
	prohibit operation are not installed on the door or				ensure proper operation and		
	frame.				document the inspection resu		
	1 1	fications to the door assembly			on the Annual Door Inspection	n log	
	have been perform	ed that void the label.			as a part of the facility's Preve	entive	
	(11) Gasketing and edge seals, where required, are		1		Maintenance Program and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023			
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST THE WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROPROFILE OF THE PROPROPROFILE OF THE PROPROPROFILE OF THE PROPROPROFILE OF THE PROPROPROFILE OF THE PROPROFILE OF T			(X5) COMPLETION DATE	
	inspected to verify to This deficient practical and staff in one smooth of the staff in one staff in on	their presence and integrity. It ice could affect 15 residents below compartment. The work of the "Fire Door Intation with the Maintenance 3 at 10:05 a.m., the form listed It is assemblies inspected It is a same and intenance Director assembly It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and It is a same and intenance Director agreed and intenance Director in the last year It is a same and intenance Director agreed and intenanc			document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrative 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 where the preventative of the Maintenance supervisor/designee to the Administrator will present the inspection results at the mont Quality Assurance/Performan 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.	are essed ne gnee ator will ance hly ce by n as		
K 0918 SS=F Bldg. 01	-	s - Essential Electric Syste s - Essential Electric						

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED	
		155582	B. WI	NG		02/28/	2023	
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			WASHINGTON ST			
WATERS	S OF WAKARLISA S	SKILLED NURSING FACILITY, TH	F		RUSA, IN 46573			
WALLE	TENO OF WARANGOA ONICEED NONGING FAGILITY, THE		_	VV/ ti O ti	10071, 111 40070			
(X4) ID	SUMMARY	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 OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	System Maintena	-						
	_	other alternate power						
		siated equipment is capable						
		ce within 10 seconds. If the						
		on is not met during the						
	1 .	ocess shall be provided to						
	1	this capability for the life						
	1	branches. Maintenance						
	1	generator and transfer						
	I	ormed in accordance with						
	NFPA 110.	re inspected weekly,						
		oad 30 minutes 12 times a						
		intervals, and exercised						
	1 -	onths for 4 continuous hours.						
	1	nder load conditions include						
		ated cold start and						
	· ·	ual transfer of all EES						
		nducted by competent						
		enance and testing of stored						
	_ ·	rces (Type 3 EES) are in						
		NFPA 111. Main and feeder						
		re inspected annually, and a						
		dically exercising the						
		tablished according to						
	1	uirements. Written records						
		nd testing are maintained						
		ble. EES electrical panels						
	1	narked, readily identifiable,						
	and separate fron	n normal power circuits.						
	Minimizing the po	ssibility of damage of the						
	emergency power	r source is a design						
	consideration for	new installations.						
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.1	` '						
		review and interview, the	K 09	918	K918 – It is the intent of the		03/20/2023	
	1	ercise the generator annually to			facility to ensure to exercise th			
	meet the requirements of NFPA 110, 2010 Edition,				generator annually to meet the			
		nergency and Standby Powers			requirements of NFPA 110, 20)10		
	Systems, Chapter 8	3.4.2. Section 8.4.2 states diesel			Edition, the Standard for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023		
		ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	E	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
	(X4) ID PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	PREFIX TAG	generator sets in seronce monthly, for a one of the following (1) Loading that magas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) name Section 8.4.2.3 state installations that do 8.4.2 shall be exerce EPSS (Emergency) shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not I nameplate kW ratin total test duration o hours. This deficient occupants. Findings include: Based on review of testing documentation Director from 09:45 the load information percentage for the conduction of the information of the information percentage for the conduction of the information of the i	R LSC IDENTIFYING INFORMATION rvice shall be exercised at least minimum of 30 minutes, using g methods: mintains the minimum exhaust recommended by the g temperature conditions and at cent of the EPS (Emergency		PREFIX TAG	Emergency and Standby Pow Systems, Chapter 8.4.2 and to ensure an annual fuel quality is performed for the facility's diesel-powered generator and ensure emergency generators equipped with a properly locat remote stop in the event the generator caught fire to meet standards. 1. CORRECTIVE ACTION TAKEN: a. On 5-17-22 the Facilitie Certified Generator Contractor conducted the annual load battest of the emergency generation and documented the results in facilities Life Safety Binder to meet set standards. See attached report. b. On 5-17-22 the Facilitie Certified Generator Contractor conducted the annual fuel qualities Life Safety Binder to meet set standards. See attached report. c. On 5-17-21 the Facilitie Certified Generator Contractor conducted the annual fuel qualities Life Safety Binder to meet set standards. See attached report. c. On 3-1-23 the Maintena Supervisor/designee posted a on the generator showing when the remote stop is located to rest standards. See attached picture 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all state and visitors have the potential be affected but none were.	ers best test to sare ded set set s r nk or the set s r nk or the set s r nk or the s	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023		
WATERS	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	30	00 N W	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility failed to ensity was performed for agenerator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA110, State Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect Findings include: Based on records reduced to be performed approved by ASTM practice could affect findings include: Based on records reduced to be performed to be performed to the service of the disselling of the service. Based on in review, the Mainten unable to find document the servicer of the graph of the servicer of the graph of the servicer of the graph of the service of the graph of the graph of the servi	sure an annual fuel quality test of 1 facility's diesel-powered 9, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient			REOCCURRENCE: a. On 3-13-23 the Administrator in serviced the Maintenance Supervisor/desig on the requirement that an ani load bank test of the emergen generator, annual fuel quality and a sign showing where the remote stop is located on the generator is required to meet a standards. b. The Maintenance Supervisor/designee will ensu annual load bank test of the emergency generator, annual quality test is conducted and documented in the life safety binder and will ensure there is emergency stop identification place to meet set standards. The Maintenance Supervisor/desig will ensure a sign is present showing there the remove stop located on the generator to me set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	gnee nual cy test, set re an fuel in The gnee	
	equipped with a pro the event the genera	operly located remote stop in ator caught fire. NFPA 110, ency and Standby Power			documentation is in place. 4. MONITORING CORRECTIVE ACTION:		
	Systems 2010 Editi- installations shall has station of a type to junintentional opera- housing the prime in	on, Section 5.6.5.6, requires all ave a remote manual stop prevent inadvertent or tion located outside the room nover, where so installed, or emises where the prime mover			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.	nce	
	is located outside th	<u>-</u>			Quality Assurance/Performan	-	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2023	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION
TAG	Section 5.6.5.6.1 restation to be labeled Annex A is not a particular included for inform A.5.6.5.6 states for manual shutdown state weatherproof en appropriately identited This deficient practical as well as staff and Findings include: Based on observation p.m. and 3:40 p.m. during a tour of the not be located or segmentator. Upon introbservation, the Mathey were unaware would be for the german and they was resulted.	art of the requirements but is ational purposes only. systems located outdoors, the hould be located external to aclosure and should be		TAG	Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.	oy n as	DATE
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vi- non-PCREE (e.g., except in long-terr do not use PCREE	ent - Power Cords and ent - Power Stript are only ents of movable ed electrical equipment eles that have been elified personnel and meet eles that have been elified personnel and meet electronical electronics), ent care resident rooms that electronical electronics entre electronical electroni					

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Facility ID: 000521

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155582	B. WI	NG		02/28	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			WASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THE	Ξ	WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the patient care rooms					
	,	meet UL 1363. In					
		ooms, power strips meet					
		ls. 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					
		ation and interview, the facility	K 09	920	K920 – It is the intent of the		03/20/2023
		f 2 power cord daisy chains		-	facility to ensure power cord d	laisy	
		d as a substitute for fixed			chains are not used as a	-	
	wiring. NFPA-70/2	011, 400.8 state unless			substitute for fixed wiring and	to	
		ed in 400.7 flexible cords and			ensure flexible cords are insta	ılled	
		used for (1) as a substitute for			properly and used in a safe		
	-	e 400.8 (1) prohibits daisy			manner to meet set standards	5.	
		first extension cord (or power			1.CORRECTIVE ACTIONS		
		as a substitute for the fixed			TAKEN:		
	-	e. This deficient practice could			1.On 3-1-23 the Maintena		
	affect 1 staff in the	Business Office.			Supervisor/designee removed		
					power strips from the Busines		
	Findings include:				office to meet set standards.		
	Dagad on abassur-4	one during a tour of the facility			Administrator verified the remo	ovai	
		ons during a tour of the facility ce Director and Executive			on 3-1-23 and 3-17-23.	anaa	
					2.On 3-1-23 the Maintena		
		3 between 1:20 p.m. and 3:40 ss Office near the front			Supervisor/designee removed	ııne	
	-	trip was plugged into and			power strip from the Social Services Office to meet set		
		another power strip. Based on			standards. The Administrator		
		e tour, the Maintenance			verified the removal on 3-1-23		
		lged the aforementioned			3-17-23	, and	
		erstrip was fixed and			2.ALL OTHERS WITH		
	disconnected at obs				POTENTIAL TO BE AFFECTE	ED:	
		- 			1.All residents and all sta		
	Findings were discu	ussed with the Maintenance			and visitors have the potential		
		tive Director at exit conference.			be affected but none were. O		
Brootor and Excounty of Brootor at exit comprehence.				3-1-23 the Maintenance			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155582	B. WING		02/28/2023
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TI	300 N	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	, i	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAU	3.1-19(b)	R ESC IDENTIFTING INFORMATION	IAU		
	3.1-19(0)			Supervisor/designee inspecte	
	2 D11			rooms throughout the facility f	
		ation and interview, the facility		power strips and found no oth	er
		of 1 flexible cords were installed		negative findings.	
		in a safe manor. NFPA 99,		3.MEASURES TO PREVEN	т
		ates adapters and extension		REOCCURRENCE:	
	1	requirements of 10.2.4.2.1		1.On 3-13-23 the	
	_	shall be permitted. Section		Administrator in serviced the	
		e cabling shall comply with		Maintenance	
		2.3.5.1 states cord strain relief		Supervisor/designee/all staff t	hat
	shall be provided a	t the attachment of the power		power strips are not to be use	d as
	cord to the applian	ce so that mechanical stress,		a substitute for fixed wiring to	
	either pull, twist, o	r bend, is not transmitted to		meet set standards.	
	internal connection	s. This deficient practice could		2.Maintenance	
	staff in the Social S	Service Office.		Supervisor/designee will inspe	ect
				all rooms throughout the facili	ty
	Findings include:			monthly to ensure they do not	•
				have power strips in use as a	
	Based on observati	on with the Maintenance		of the facility's Preventive	'
	Director and Execu	ntive Director on 02/28/23		Maintenance Program and	
		and 3:40 p.m., in the Social		document those inspection re-	sults
	_	power strip used to power		as appropriate. If any issues	
	1	t secured, and was dangling in		discovered, they will be addre	
	* *	oinet. This condition could put		and resolved immediately. Th	
		cord causing damage to the		Maintenance Supervisor/design	
	_	on interview at the time of		will review with the Administra	
	1 -	faintenance Director agreed			itoi
	1	s dangling, not secured, and		the inspection results. 3.The Administrator will	
		rip will need to be mounted or		monitor adherence to the	
	_	np will need to be mounted or he powerstrip was fixed and			
				Preventative Maintenance	
	secured at observat	IOII.		schedule and validate the	
	Tr. C. 1.	1 14 4 35 1		Preventative Maintenance	
		eviewed with the Maintenance		documentation is in place.	n (=
		ntive Director during the exit		4.MONITORING CORRECT	IVE
	conference.			ACTION:	
				1.The inspection results	
	3.1-19(b)			be presented by the Maintena	ince
				Supervisor/designee to the	
	I			Administrator monthly and the	·

Administrator will present the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	· ′	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 02/28	LETED
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE				300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3-20-23.	ce	

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