PRINTED: 04/28/2023
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0	1938-039
STATEMENT 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		04/17/2023		
100002					0 1/11/2020	
NAME OF E	ROVIDER OR SUPPLIEI	D	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	KOVIDEK OK SUFFLIEI	X.	300 N	WASHINGTON ST		
WATERS	OF WAKARUSA	SKILLED NURSING FACILITY, TH	HE WAKA	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	COM	PLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	D.	ATE
K 0000						
Bldg. 01						
	A Post Survey Rev	isit (PSR) to the Life Safety	K 0000			
	-	on and State Licensure Survey	K 0000			
		8/23 was conducted by the				
	-	t of Health in accordance 42				
	CFR Subpart 483.9	90(a).				
	Survey Date: 04/17	7/23				
	Facility Number: (	000521				
	Provider Number: 155582					
	AIM Number: 100	266980				
	At this Life Safety	Code PSR, The Waters of				
	-	Nursing Facility was found not				
		Requirements for Participation				
	_	aid, 42 CFR 483.90(a), Life				
		and the 2012 edition of the				
	-					
		ection Association (NFPA) 101,				
		LSC), Chapter 19, Existing				
	Health Care Occup	ancies.				
		lity was determined to be of				
	Type V (000) const	truction and was fully				
		acility has a fire alarm system				
	with smoke detection	on in the corridors and in areas				
	open to the corridor	rs. 73 resident rooms were				
	*	ery operated smoke detectors.				
	The facility is parti					
		) kW emergency generator. The				
	-	tified beds. 109 are dually				
	-					
		are and Medicaid; 24 are				
		are only. At the time of the				
	survey, the census	was 101.				
	Quality Review con	mpleted on 04/18/23				
				1		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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.

PRINTED: 04/28/2023 FORM APPROVED OMB NO. 0938-039

LENTERS FUL	K MEDICARE & MEDIC	_				OM	D NO. 0936-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155582	B. WING			04/17/2023	
				OTD FET A	DDDEGG CITY CTATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			,_ <b> </b>		VASHINGTON ST		
WATERS	5 OF WAKARUSA S	SKILLED NURSING FACILITY, TE	1⊏	WANAR	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	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01	Electrical Systems	s - Essential Electric					
	System Maintena	nce and Testing					
	The generator or	other alternate power					
	source and assoc	iated equipment is capable					
	of supplying service	ce within 10 seconds. If the					
	10-second criterio	n is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm t	his capability for the life					
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	1 .	nths for 4 continuous hours.					
		der load conditions include					
	a complete simula	ated cold start and					
	•	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	1 -	rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r	•					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view and interview, the facility	K 09	110	DISCLAIMER STATEMENT:		04/21/2023
		e generator annually to meet	K 09	10	Preparation and/or execution	•	0 <del>4</del> /41/4043
	I miled to exercise th	e generator annually to illect	1		i reparation and/or execution		

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

Event ID:

XH0322

Facility ID: 000521

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582  NAME OF PROVIDER OR SUPPLIER  WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG Systems, Chapter 8.4.2. Section 8.4.2 states diesel  TO PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Of this plan of correction in general, or this corrective action in particular, does not corrective action in particular, does not constitute an extension of the corrective action in particular, does not constitute an extension of the corrective action in particular, does not constitute an extension of the correction of the corrective action in particular, does not constitute an extension of the correction of the corrective action in particular, does not constitute an extension of the correction of the correction of the corrective action in particular, does not constitute an extension of the correction of the corr	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573  (X5) PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  of this plan of correction in general, or this corrective action in particular, does not	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  300 N WASHINGTON ST WAKARUSA, IN 46573  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY)  Of this plan of correction in general, or this corrective action in particular, does not	155582		155582	B. WING		04/17/2023	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  (X5)  PREFIX  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION  (EACH CORRECTION ACTION SHOULD BE (COMPLETION DATE)  Of this plan of correction in general, or this corrective action in particular, does not							
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  PREFIX PREFIX TAG  PREFIX TAG  Of this plan of correction in general, or this corrective action in particular, does not	WATERS	S OF WAKARUSA S	SKILLED NURSING FACILITY, THE	E WAKA	RUSA, IN 46573		
the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  TAG  of this plan of correction in general, or this corrective action in particular, does not	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTION	(X5)	
the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  TAG  of this plan of correction in general, or this corrective action in particular, does not	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  general, or this corrective action in particular, does not	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel  general, or this corrective action in particular, does not		the requirements of	f NFPA 110, 2010 Edition, the		of this plan of correction in		
Systems, Chapter 8.4.2. Section 8.4.2 states diesel action in particular, does not		Standard for Emerg	gency and Standby Powers		1		
		_			1 -	t	
generator sets in service shall de exercised at least			ervice shall be exercised at least		constitute an admission or		
once monthly, for a minimum of 30 minutes, using agreement by this facility of the		_	1 7			the	
		one of the following methods:			1 -		
(1) Loading that maintains the minimum exhaust forth in this statement of					_		
gas temperatures as recommended by the deficiencies. The plan of							
manufacturer correction and specific			•				
(2) Under operating temperature conditions and at corrective actions are prepared		(2) Under operating	g temperature conditions and at			red	
not less than 30 percent of the EPS (Emergency and/or executed in compliance							
Power Supply) nameplate kW rating. with state and federal laws.					-		
Section 8.4.2.3 states diesel-powered EPS  This plan of correction		11.07					
		installations that do not meet the requirements of				ion	
·		8.4.2 shall be exercised monthly with the available			_		
		EPSS (Emergency Power Supply System) load and					
shall be exercised annually with supplemental Medicaid requirements.					Medicaid requirements.		
loads (Load Bank Test) at not less than 50 percent  K918 – It is the intent of the					-		
of the EPS nameplate kW rating for 30 continuous facility to ensure to exercise the		1				ne	
minutes and at not less than 75 percent of the EPS generator annually to meet the		minutes and at not l					
nameplate kW rating for 1 continuous hour for a requirements of NFPA 110, 2010		_			1 -		
total test duration of not less than 1.5 continuous Edition, the Standard for		-			Edition, the Standard for		
hours. This deficient practice could affect all Emergency and Standby Powers		hours. This deficient practice could affect all			Emergency and Standby Pow	ers	
occupants. Systems, Chapter 8.4.2 to meet		-			Systems, Chapter 8.4.2 to me	et	
set standards.					set standards.		
Findings include: 1. CORRECTIVE ACTIONS		Findings include:	Findings include:		1. CORRECTIVE ACTION	IS	
TAKEN:					TAKEN:		
Based on review of monthly generator load a. On 4-21-23 the Facilities		Based on review of monthly generator load			a. On 4-21-23 the Facilitie	:s	
testing documentation with the Maintenance Certified Generator Contractor		testing documentati	ion with the Maintenance			•	
Director from 12:50 p.m. to 1:45 p.m. on 04/17/23, conducted the annual load bank					conducted the annual load ba	nk	
the load information to show the actual load test of the emergency generator					test of the emergency general	tor	
percentage for the diesel powered generator was and ensured it was tested at 30%		percentage for the diesel powered generator was			and ensured it was tested at 3	30%	
documented and was less than 30%. Based on and higher of the name plate KW					and higher of the name plate KW		
interview at the time of record review, the rating to meet set standards.		interview at the tim	interview at the time of record review, the		rating to meet set standards.		
Maintenance Director acknowledged the 2. ALL OTHERS WITH			Maintenance Director acknowledged the		2. ALL OTHERS WITH		
generator ran under load on a monthly basis but  POTENTIAL TO BE AFFECTED:		generator ran under	r load on a monthly basis but		POTENTIAL TO BE AFFECT	ED:	
does not achieve 30 % of the name plate rating.  a. All residents and all staff		does not achieve 30	0 % of the name plate rating.		a. All residents and all sta	ff	
The only documentation the Maintenance and visitors have the potential to		The only document	tation the Maintenance		and visitors have the potential	l to	
Director could provide was a service ticket from be affected but none were.		Director could prov	vide was a service ticket from		be affected but none were.		
the contracted generator service company which  3. MEASURES TO PREVENT		the contracted gene	erator service company which		3. MEASURES TO PREVI	ENT	

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 04/17/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			300 N	STREET ADDRESS, CITY, STATE, ZIP COD  300 N WASHINGTON ST  WAKARUSA, 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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE			
	bank. Based on intereview, the Mainter will contact the gen an annual load bank.  This finding was re Director and Execution conference.  This deficiency was	quirements of an annual load erview at the time of record nance Director stated that they herator company and schedule is test as soon as possible.  Viewed with the Maintenance tive Director at the exit  Is cited on 02/28/23. The facility is a systemic plan of correction ences.		REOCCURRENCE:  a. On 4-17-23 and 4-24- Administrator inserviced the Maintenance Supervisor/des on the requirement that a mand annual load bank test of emergency generator must be conducted and achieve 30% name plate KW rating to me standards.  b. The Maintenance Supervisor/designee will ensemonthly and annual load band of the emergency generator conducted and achieve 30% name plate KW rating as a public than the facility's Preventive Maintenance Program and document those inspection in as appropriate. If any issued discovered, they will be addited and resolved immediately. Maintenance Supervisor/designee will review with the Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  2. MONITORING CORRECTIVE ACTION:  a. The inspection results be presented by the Mainter Supervisor/designee to the Administrator will present the inspection results at the mor Quality Assurance/Performance	signee onthly if the oe of the et set sure a nk test is of the eart of essults as are ressed. The signee rator will nance the enthly in the en			

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

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CENTERSTON	WIEDICAKE & WIEDICA	AID SERVICES				ON	D 110. 0730-037
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
155582			B. WING 04/17/2023				2023
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD  300 N WASHINGTON ST  WAKARUSA, IN 46573				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					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	by n as	

4-21-2023.

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