STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. BUILDING -- B. WING	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/11/23 Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930 At this Emergency Preparedness survey, The Waters of Rushville Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 98 certified beds. At the time of the survey, the census was 46. Quality Review completed on 01/19/23	E 0000	**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 the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Busald	Administrator	02/02/2023

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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	emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.75(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with clients, their families or representatives. Based on interview at the time of records review, the Executive Director agreed after looking through the EPP the aforementioned policy was not in the provided EPP Binder. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m.	E 0035	**E035**– It is the intent of the facility to ensure the Emergency Preparedness Plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.75(c)(8) to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 02/01/2023 the Administrator and the Maintenance Supervisor/designee updated the facility's Emergency Preparedness Policy Manual to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives to meet set standards. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. The	02/02/2023

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			facility has only one Emergency Preparedness Policy Manual. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that the facility's Emergency Preparedness Policy Manual must include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives to meet set standards. b) On 02/01/2023 the Administrator in serviced all staff on the updated Emergency Preparedness Policy Manual to meet set standards. c) Maintenance Supervisor/designee will work with the Administrator to review the Emergency Preparedness Policy Manual at least annually and to update the Policy as frequently as necessary. If any issues are discovered, they will be addressed and resolved immediately. d) The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee	

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			will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3,			

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	and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a			

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	document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.	E 0041	**E041**– It is the intent of the facility to ensure to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110 and Life Safety Code in accordance with 42 CFR 483.73(e)	02/02/2023

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	Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes since 10-3-22. Weekly tests were also missing. Based on an interview at the time of record review, the Executive Director at the time stated it was her belief that the monthly generator tests and the weekly tests were being done, but the facility was currently without a maintenance professional and no documentation showing current testing could be located. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m.		(2) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/27/2023 the Maintenance Supervisor conducted the monthly generator testing for a minimum of 30 minutes and conducted the weekly test and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that a monthly generator test must be conducted for a minimum of 30 minutes along with the weekly tests and documented in the facilities Life Safety Binder to meet set standards. b. The Maintenance Supervisor/designee will ensure a monthly 30 minute at minimum generator test is conducted along with the weekly generator tests and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. 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 02/02/2023.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/11/23 Facility Number: 000018 Provider Number: 155053	K 0000	**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 the facts alleged or conclusions set forth in this statement of**	

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	AIM Number: 100273930 At this Life Safety Code survey, The Waters of Rushville Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 98 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. The facility had two detached wooden storage buildings which were not sprinkled. Quality Review completed on 01/19/23		**deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by			

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	construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 2 of 2 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect all residents. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the set of double fire barrier doors separating the Skilled nursing from the Assisted Living occupancies, near Resident Rooms #60 and 61, near the Breezeway, did not close and latch. The Executive Director agreed the aforementioned doors did not have latching hardware. This finding was acknowledged by the Executive Director at the time of discovery and again at the	K 0131	**K131**– It is the intent of the facility to ensure separation fire doors would limit the spread of fire and restrict the movement of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. The Maintenance Supervisor/designee will repair the latching hardware to self-close on the set of double fire barrier doors separating the Skilled nursing from the Assisted Living occupancies, near resident rooms #60 & 61, near the breezeway to meet set standards by 02/16/2023. The Administrator will verify upon completion. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 02/01/2023 the Maintenance Supervisor/designee inspected all doors and found no other negative findings.	02/16/2023

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	exit conference at 4:45 p.m. 3.1-19(b)		**3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor on the requirement to ensure to provide properly rated fire resistive barriers and or self-closing and automatic latching doors in a fire barrier wall to meet set standards. b. Maintenance Supervisor/designee will inspect all doors throughout the facility monthly to ensure they are properly maintained, self-close and latch fully into frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			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 02/16/2023.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.	K 0211	**K211** – It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of obstructions to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/11/2023 the Maintenance Supervisor/designee removed the Personal Protective Equipment (PPE) cart that was in use but not equipped with wheels near resident room #12 to meet set standards. The Administrator	02/02/2023

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WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

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	(c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 6 residents in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., near Resident Room #12 a Personal Protective Equipment (PPE) cart was in use but not equipped with wheels allowing the carts to be move out of the halls during an emergency. Based on an interview at the time of observations, the Executive Director stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)		verified the work on 01/11/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/11/2023 the Maintenance Supervisor/designee inspected all corridor means of egress and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement that the corridor means of egress are to remain free of obstructions to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor means of egress throughout the facility weekly for obstructions as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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	155053	A. BUILDING 01 B. WING	01/11/2023

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			documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exits with special locking arrangements for the clinical security needs of the residents were readily accessible by remote control of locks; keys carried by staff at all times; or other such reliable means available to the staff at all times. This deficient practice could affect 25 residents. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the exit door #10 was locked, could be opened by entering a four-digit code, but when asked to open the door, the staff person did not enter the correct code and could not open the door. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)	K 0222	**K222 -** It is the intent of the facility to ensure means of egress through exits with special locking arrangements for the clinical security needs of the residents are readily accessible by remote control of locks, keys carried by staff at all times, or other such reliable means available to the staff at all times to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/11/2023 the Maintenance Supervisor/designee posted information to obtain the code by the door at exit door #10, also all doors will automatically release upon activation of the fire alarm system to meet set standards. The Administrator verified the posting of the codes on 01/11/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/30/2023 the Maintenance Supervisor/designee inspected all	02/02/2023

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			doors to the means of egress to ensure they were readily accessible for use and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that doors must be readily accessible for use to meet set standards. b. Maintenance Supervisor/designee will inspect all means of egress throughout the facility weekly to ensure doors are readily accessible for use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			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 02/02/2023.**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the	K 0300	**K300**– It is the intent of the facility to ensure documentation for the preventative maintenance of battery-operated smoke alarms in resident rooms is complete to meet set standards. **1) CORRECTIVE ACTIONS TAKEN**: a) On 01/30/2023 the Maintenance Supervisor/designee replaced the batteries in the smoke detector that had batteries that expired on 1/1/23 and documented the information on the	02/02/2023

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	equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., the documentation entitled "Millers Merry Manor Battery Operated Smoke Detector Maintenance Log for year 2022" indicated the batteries expired on 1/1/23, and no documentation was available indicating the batteries had been changed. The Executive Director stated that she was unsure if the batteries had been changed in the last year, but suspected they had not. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)		Battery-Operated Smoke Detector Maintenance Log to meet set standards. The Administrator verified the work on 02/02/2023. **2) ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a) All residents and all staff and visitors have the potential to be affected but none were. **3) MEASURES TO PREVENT REOCCURRENCE**: a) On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that battery operated smoke alarms must be maintained per manufacture's guidelines and documentation retained at the facility to meet set standards. b) Maintenance Supervisor/designee will ensure the battery-operated smoke detectors are maintained per manufactures guidelines and document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c) The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. **4) MONITORING CORRECTIVE ACTION**: a) The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and			

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	supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the fire alarm control panel (FACP) door was not locked, and the key was in the FACP door. The FACP is located in a high traffic area in the main corridor near the entrance to the facility. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)	K 0341	**K341** – It is the intent of the facility to ensure fire alarm control panels are protected to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/11/2023 the Maintenance Supervisor/designee removed the key that was in the FACP door and locked the door to meet set standards. The Administrator verified the work on 01/11/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/12/2023 the Maintenance Supervisor/designee inspected all other areas and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement that fire alarm control panels are protected to meet set standards. b. Maintenance Supervisor/designee will inspect all fire alarm control panels to ensure they are protected and	02/02/2023

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			locked as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 3 staff. Findings include:	K 0353	**K353** – It is the intent of the facility to ensure sprinkler heads in the laundry area are not loaded or covered with foreign material in accordance with LSC 9.7.5 and to ensure sprinkler systems are provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 01/30/2023 a Licensed Sprinkler Contractor/Maintenance Supervisor/designee repaired the two sprinkler heads in the laundry that were covered in dust or showed signs of loading to meet	02/16/2023

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	Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., 2 of 4 sprinkler heads in the laundry were coved in dust or showed signs of loading. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., there was one spare sprinkler cabinet in the riser room that included 15 spare sprinklers; 4 of which were not in their own protected slot. They were stored loose in the cabinet and not secured in holders. 4		set standards. The Administrator verified the work on 02/02/2023. 2.The Licensed Sprinkler Contractor/Maintenance Supervisor/designee will install a second sprinkler cabinet so each sprinkler would have it's own protected slot and will ensure the additional spare sprinkler heads are new and meet set standards by 02/16/2023. The Administrator will verify the work upon completion. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are provided with spare sprinkler heads secured in their own protective slots as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the	

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	additional spare sprinkler heads showed signs of previous installation and did not appear to be new. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)		inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/16/2023.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20			

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WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and residents.	K 0363	**K363** – It is the intent of the facility to ensure corridor doors have no impediment to closing and latching into the door frame and would resist the passage of smoke to meet set standards.	02/02/2023

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	Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the corridor doors to (1) West Wing Nurses Supply room equipped with a self-closing device, failed to self-close and latch into the door frame. And (2) the West Wing Nurses Station "Staff Break Room" Door failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Executive Director agreed the aforementioned corridor doors did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 3 staff. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the corridor door to the Dietary Supply on the service hall had a ½ inch hole which penetrated completely through the door near the doorknob. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m.		**1. CORRECTIVE ACTIONS TAKEN**: a. On 01/30/2023 the Maintenance Supervisor/designee 1) repaired the door closer on the corridor doors to west wing nurses supply room to ensure they self-close and latch into the door frame and 2) repaired the door closer on the west wing nurses station staff break room/medical supply room to ensure it self-closes and latches into the door frame to meet set standards. The Administrator verified the work on 02/02/2023. b. On 01/30/2023 the Maintenance Supervisor/designee repaired the area near the doorknob in the corridor door to the Dietary Supply on the service hall to meet set standards. The Administrator verified the work on 02/02/2023. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors for impediments to closing and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors may not have	

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	3.1-19(b)		impediments to closing and must self-close and latch fully into the frame and perform monthly inspections of the corridor doors to ensure no penetrations in the doors to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure there are no impediments to closing and they self-close and latch fully into the frame and perform inspections of the corridor doors to ensure no penetrations in the doors as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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			Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing	K 0511	**K511 -** It is the intent of the facility to ensure all electrical panels in the corridors are secured from non- authorized personnel to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/11/2023 the Maintenance Supervisor/designee locked the following electrical boxes: 1. West Wing Middle Corridor Lighting box 2. Box marked W-4 air conditioning and 3. 2 boxes on the East Hall to meet set standards. The Administrator verified the work on	02/02/2023

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	access to energized parts shall be provided. This deficient practice could affect staff and 30 residents. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the following electrical panels in were unlocked when tested: 1. West Wing Middle corridor "Lighting" box. 2. Box marked "W-4 Air Conditioning." 3. 2 of 5 Boxes on the East Hall. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)		02/02/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 01/27/2023 the Maintenance Supervisor/designee inspected all electrical boxes to ensure they were locked and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that all electrical panels are secured from non-authorized personnel to meet set standards. b. Maintenance Supervisor/designee will inspect all electrical panels are secured from non-authorized personnel on a weekly basis as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility	K 0712	**K712** – It is the intent of the	02/03/2023

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	failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) Second quarter, second shift of 2021. b) Fourth quarter, third shift of 2021. Based on interview at the time of record review, the Executive Director agreed there were some missing fire drills and staff has not been trained in the fire safety procedures for the second and fourth quarters. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b) 3.1-51(c)		facility to ensure to conduct quarterly fire drills or documented orientation training on each shift for 4 quarters per year to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b. The Maintenance Supervisor/designee will conduct a fire drill/training for each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards by 02/03/2023. The Administrator will verify the drills upon completion. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and documented on the Fire Drill Report and that documentation be retained in the facility's Life Safety Binder as a	

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			part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/03/2023.**	

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K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels were in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the generator annunciator panel had a yellow service light which was illuminated and when tested and reset at the panel by the surveyor, continued to illuminate yellow. The Executive Director stated that the generator had recently run and she was unaware of any issues with the Generator, but the facility is currently without a full-time maintenance professional. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m.	K 0916	**K916**– It is the intent of the facility to ensure the emergency generator annunciator panels are in proper operating condition to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/12/2023 the Maintenance Supervisor/designee repaired the generator to ensure the yellow service light is not illuminated to meet set standards. The Administrator verified repairs on 01/12/2023. 2. **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one emergency generator. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee	02/02/2023

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	3.1-19(b)		on the requirement the emergency generator annunciator panels are in proper operating condition to meet set standards. b. Maintenance Supervisor/designee will ensure the emergency generator annunciator panels are in proper operating condition as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,			

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	and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for all of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes since 10-3-22. Based on an interview at the time of record review, the Executive Director at the time stated it was her belief that the monthly generator tests were being done, but the facility was currently without a maintenance professional and no documentation showing current testing could be located. of discovery and again at the exit conference at 4:45 p.m.	K 0918	**K918** – It is the intent of the facility to ensure to maintain a complete written record of monthly generator load testing for all of the last 12 months and ensure a written record of weekly inspections for the generator is maintained for the year and to ensure emergency task generator battery backup lights are maintained to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 01/27/2023 the Licensed generator contractor/Maintenance Supervisor conducted the monthly 30 minute generator test and documented the results in the facilities Life Safety Binder to meet set standards. b. On 01/27/2023 the Maintenance Supervisor/designee conducted the weekly inspection of the generator and documented the results in the facilities Life Safety Binder to meet set standards. c. The Maintenance Supervisor/designee will conduct the annual 90 minute test and monthly 30 second test of the emergency generator battery backup lights and will document	02/16/2023

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WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 51 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., the only record available for review to show the diesel generator sets in service was inspected weekly was dated 12/30 however no year was indicated on the form entitled "Emergency Generator - Weekly Inspection Checklist.". Based on an interview at the time of record review, the Executive Director stated it was her belief that the weekly generator tests were being done, but the facility was currently without a maintenance professional and no documentation showing current testing could be located. . This finding was acknowledged by the Executive		the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that a monthly 30 minute generator test for 30 minutes is required, along with a weekly inspection, annual 90 minute test and monthly 30 second test to meet set standards. b. The Maintenance Supervisor/designee will ensure monthly 30 minute generator test for 30 minutes is conducted monthly, along with a weekly inspection, annual 90 minute test and monthly 30 second test and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the	

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	Director at the time of discovery and again at the exit conference at 4:45 p.m. 3. Based on records review and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review and interview with the Executive Director on 1/11/23 between 1:15 a.m. and 1:20 p.m., no documentation was available for review to show the emergency battery powered light at the generator was tested annually for (1) a minimum of 90 minutes, or that (2) monthly 30 second testing had been completed each month. The provided documentation entitled, "Battery-Operated Emergency Lights and Signs Test Log" for calendar year 2022 did not indicated a 90 minute test had been done, and the aforementioned documentation omitted monthly testing for January - July of 2022.		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 02/16/2023.**	

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	This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for	K 0920	**K920** – It is the intent of the facility to ensure power cord daisy chains are not used as a substitute for fixed wiring to meet set standards. **1.CORRECTIVE ACTIONS**	02/02/2023

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	fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., in the Medical Records office a power strip was plugged into another power strip and supplied power by another power strip and being used to supply power to equipment. Based on interview at the time of observation, the Executive Director agreed the aforementioned power strips were daisy chained together. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)		**TAKEN**: 1.On 01/11/2023 the Maintenance Supervisor/designee removed the power strips from the Medical Records office to meet set standards. The Administrator verified the removal on 01/11/2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 01/12/2023 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and found no other negative findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/designee/all staff that power strips are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator	

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			the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 02/02/2023.**	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents Findings include: Based on observations and interviews during a tour of the facility with the Executive Director on 1/11/23 between 1:15 p.m. and 4:00 p.m., the oxygen storage/transfer room had a sign indicting that transferring of oxygen was always occurring in the room, and did not have the ability to indicate when transfilling was not occurring. Based on interview at the time of observation, the Executive Director stated there was not a sign stating when trans-filling oxygen is occurring and not occurring. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference at 4:45 p.m. 3.1-19(b)	K 0927	**K927**– It is the intent of the facility to ensure oxygen storage/transfer rooms are provided with a sign indicating that transferring is occurring to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On 01/30/2023 the Maintenance Supervisor/designee installed a sign on the oxygen storage/transfer room indicating to show when transfilling is occurring and not occurring to meet set standards. The Administrator verified this on 01/30/2023. **1.ALL OTHERS WITH POTENTAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: a. On 02/01/2023 the DON/designee will monitor the oxygen transfilling procedure to ensure all nursing staff is meeting set requirements per our Oxygen Policy & Procedures to meet set standards. b. The DON/designee will monitor adherence to the oxygen transfilling procedure per our Oxygen Policy and Procedures.	02/02/2023

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			c. The maintenance Supervisor will ensure the Oxygen Storage Room signage is present as a part of the facility's Oxygen Storage Room Policy & Procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. d. The Administrator will monitor adherence to the Oxygen Policy & Procedure and validate the Preventative Maintenance documentation is in place. **1.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee/DON/designe e 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 02/02/2023.**	

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