|  | VT OF HEALTH AND HI<br>OR MEDICARE & MEDI   |  |          |                     |   |                                     | RM APPROVED<br>B NO. 0938-039 |
|--|---|--|----------|---------------------|---|-------------------------------------|-------------------------------|
| STATEME                                  | ENT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  |          | JILDING             | ONSTRUCTION   | (X3) DATE<br>COMPI<br>01/11,        | SURVEY<br>.ETED               |
|  | PROVIDER OR SUPPLIE   | R<br>SKILLED NURSING FACILITY, TI  | HE       | 612 E               | address, city, state, zip cod<br>11TH ST<br>VILLE, IN 46173   |                                     |                               |
| (X4) ID<br>PREFIX<br>TAG<br>E 0000       | (EACH DEFICIE   | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION   |          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   |                                     | (X5)<br>COMPLETION<br>DATE    |
| E 0000<br>Bldg<br>E 0035<br>SS=C<br>Bldg | conducted by the L<br>accordance with 4<br>Survey Date: 01/1<br>Facility Number:<br>Provider Number:<br>AIM Number: 10<br>At this Emergency<br>Waters of Rushvil<br>found not in comp<br>Preparedness Req<br>Medicaid Particips<br>CFR 483.73.<br>The facility has 98<br>the survey, the cer<br>Quality Review co<br>483.475(c)(8), 48<br>LTC and ICF/IID<br>§483.73(c)(8); §4<br>*[For LTC Faciliti<br>[(c) The LTC faci<br>maintain an eme<br>communication p<br>Federal, State ar<br>reviewed and up<br>communication p<br>following:] | 11/23<br>000018<br>155053<br>0273930<br>7 Preparedness survey, The<br>le Skilled Nursing Facility was<br>diance with Emergency<br>uirements for Medicare and<br>ating Providers and Suppliers, 42<br>8 certified beds. At the time of<br>nsus was 46.<br>0 mpleted on 01/19/23<br>33.73(c)(8)<br>Sharing Plan with Patients<br>483.475(c)(8)<br>ies at §483.73(c):]<br>dity must develop and<br>rgency preparedness<br>olan that complies with<br>nd local laws and must be<br>dated at least annually. The<br>olan must include all of the<br>§483.475(c):] | Ε0       | 000                 | DISCLAIMER STATEMENT:<br>Preparation and/or execution<br>of this plan of correction in<br>general, or this corrective<br>action in particular, does not<br>constitute an admission or<br>agreement by this facility of<br>facts alleged or conclusions<br>forth in this statement of<br>deficiencies. The plan of<br>correction and specific<br>corrective actions are prepara<br>and/or executed in compliant<br>with state and federal laws.<br>This plan of correction<br>constitutes a written allegat<br>of substantial compliance w<br>Federal Medicare and<br>Medicaid requirements. | ot<br>f the<br>s set<br>ared<br>nce |                               |
|  |   | must develop and maintain an   |          |                     |   |                                     |                               |
| LABORATO                                 |   | OVIDER/SUPPLIER REPRESENTATIVE'S SI  | ignatur] | E<br>Administ       | TITLE   |                                     | (X6) DATE<br>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.

PRINTED: 02/10/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2023 FORM APPROVED

| OMB | NO. | 0938-039 |  |
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|                          | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | î î  | ILDING<br>NG        |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023                                    |                           |
|--------------------------|--|--|------|---------------------|--|--|---------------------------|
|                          | NAME OF PROVIDER OR SUPPLIER WATERS OF RUSHVILLE SKILLED NURSING FACILITY, TH  |  |      | 612 E <sup>-</sup>  | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | ле   | (X5)<br>COMPLETIC<br>DATE |
|                          | <ul> <li>plan that complies</li> <li>local laws and multiplication of the second state of the second state</li></ul> | view and interview with the<br>on 1/11/23 between 1:15 a.m.<br>Emergency Preparedness Binder<br>ddress a method for sharing<br>ned within the EPP Binder that<br>appropriate with clients, their<br>ntatives. Based on interview at<br>review, the Executive Director<br>g through the EPP the<br>licy was not in the provided | E 00 | 035                 | <ul> <li>E035– It is the intent of the fact to ensure the Emergency Preparedness Plan (EPP) includes a method for sharing information from the emergen plan that the facility has determined is appropriate with residents and their families or representatives in accordance 42 CFR 483.75(c)(8) to meet standards.</li> <li>1) CORRECTIVE ACTIONS TAKEN: <ul> <li>a) On 02/01/2023 the Administrator and the Maintenance Supervisor/desig updated the facility's Emerger Preparedness Policy Manual finclude a method for sharing information from the emergen plan that the facility has determined is appropriate with residents and their families or representatives to meet set standards.</li> </ul> </li> <li>2) ALL OTHERS WITH POTENTIAL TO BE AFFECTI a) All residents and all sta and visitors have the potential be affected but none were. The parent of the standards and updates and the standards.</li> </ul> | cy<br>h<br>with<br>set<br>S<br>gnee<br>hcy<br>to<br>cy<br>h<br>ED:<br>ff<br>to | 02/02/20                  |

|               | T OF DEFICIENCIES<br>DF CORRECTION | CAID SERVICES<br>X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053 | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION   | (X3) DATE SU<br>COMPLE<br>01/11/2   | TED              |
|---------------|------------------------------------|--|--|---|---|------------------|
|               | ROVIDER OR SUPPLIE                 | R<br>SKILLED NURSING FACILITY, TI  | 612 E <sup>-</sup>                         | address, city, state, zip cod<br>11TH ST<br>/ILLE, IN 46173   |   |                  |
| (X4) ID       |                                    | STATEMENT OF DEFICIENCIE   |  |   |   | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIE                      | NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION                  | PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)   | Ē   | COMPLETI<br>DATE |
|               |                                    |  |  | facility has only one Emergence<br>Preparedness Policy Manual.<br>3) MEASURES TO PREVER<br>REOCCURRENCE:<br>a) On 01/30/2023 the<br>Administrator in serviced the<br>Maintenance Supervisor/desig<br>on the requirement that the<br>facility's Emergency Preparedre<br>Policy Manual must include a<br>method for sharing information<br>from the emergency plan that the<br>facility has determined is<br>appropriate with residents and<br>their families or representatives<br>meet set standards.<br>b) On 02/01/2023 the<br>Administrator in serviced all state<br>on the updated Emergency<br>Preparedness Policy Manual to<br>meet set standards.<br>c) Maintenance<br>Supervisor/designee will work<br>the Administrator to review the<br>Emergency Preparedness Policy<br>Manual at least annually and to<br>update the Policy as frequently<br>necessary. If any issues are<br>discovered, they will be address<br>and resolved immediately.<br>d) The Administrator will<br>monitor adherence to the<br>Emergency Preparedness Policy<br>Manual and validate the<br>documentation is in place.<br>4) MONITORING<br>CORRECTIVE ACTION:<br>a) At least annually to ensu-<br>compliance, the Administrator<br>Maintenance Supervisor/designees in the set of the set of the<br>Manual and validate the<br>documentation is in place.<br>4) MONITORING<br>CORRECTIVE ACTION:<br>a) At least annually to ensu-<br>compliance, the Administrator | NT<br>nee<br>ness<br>the<br>s to<br>aff<br>cy<br>v as<br>ssed<br>cy<br>ure<br>and | DATE             |

|                          | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | ER A. BUILDING  |                     | ONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |                           |
|--------------------------|---|--|---|---------------------|---|---|---------------------------|
|                          | PROVIDER OR SUPPLIEF<br>S OF RUSHVILLE S  | KILLED NURSING FACILITY, T   | STREET ADDRESS, CITY, STATE, ZIP COD<br>612 E 11TH ST<br>HE RUSHVILLE, IN 46173 |                     |   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | E   | (X5)<br>COMPLETIO<br>DATE |
|                          |   |  |   |                     | will review the Emergency<br>Preparedness Policy Manua<br>make changes as necessar<br>meet set standards. Those<br>reviews will be documented<br>appropriate.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance w<br>all regulatory requirements<br>Our date of compliance is<br>02/02/2023. | y to<br>as<br><b>⁄ith</b>                   |                           |
| : 0041<br>SS=F<br>Bldg   | §482.15(e) Condit<br>(e) Emergency an<br>The hospital must<br>standby power sys<br>emergency plan s<br>this section and in<br>procedures plan s<br>(i) and (ii) of this s<br>§483.73(e), §485.<br>(e) Emergency an<br>The [LTC facility a<br>implement emerge<br>systems based or<br>forth in paragraph<br>§482.15(e)(1), §48<br>Emergency gener<br>generator must be | LTC Emergency Power<br>ion for Participation:<br>d standby power systems.<br>implement emergency and<br>stems based on the<br>et forth in paragraph (a) of<br>the policies and<br>et forth in paragraphs (b)(1)<br>ection.<br>625(e)<br>d standby power systems.<br>ind the CAH] must<br>ency and standby power<br>the emergency plan set<br>(a) of this section.<br>63.73(e)(1), §485.625(e)(1) |   |                     |   |   |                           |
|                          | Care Facilities Co<br>Interim Amendme<br>12-4, TIA 12-5, ar<br>Code (NFPA 101   | ements found in the Health<br>de (NFPA 99 and Tentative<br>nts TIA 12-2, TIA 12-3, TIA<br>d TIA 12-6), Life Safety<br>and Tentative Interim<br>12-1, TIA 12-2, TIA 12-3,   |   |                     |   |   |                           |

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

|                   | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |                  |
|-------------------|--|--|--|--|---|------------------|
|                   | PROVIDER OR SUPPLIEF<br>S OF RUSHVILLE S   | R<br>KILLED NURSING FACILITY, T  | 612 E 1                                    | address, city, state, zip co<br>11TH ST<br>/ILLE, IN 46173   | DO  |                  |
| (X4) ID<br>PREFIX | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | OULD BE                                     | (X5)<br>COMPLETI |
| TAG               | REGULATORY OF<br>and TIA 12-4), an<br>structure is built o<br>structure or buildin<br>482.15(e)(2), §48<br>Emergency gener<br>The [hospital, CAI<br>implement the em-<br>inspection, testing<br>requirements four<br>Facilities Code, N<br>Code.<br>482.15(e)(3), §48<br>Emergency gener<br>and LTC facilities<br>source to power en<br>have a plan for ho<br>power systems op<br>emergency, unless<br>*[For hospitals at<br>§483.73(g), and C<br>The standards inor<br>this section are ap<br>reference by the I<br>Federal Register i<br>552(a) and 1 CFR<br>the material from<br>You may inspect a<br>Information Resou | A LSC IDENTIFYING INFORMATION<br>d NFPA 110, when a new<br>r when an existing<br>ng is renovated.<br>3.73(e)(2), §485.625(e)(2)<br>ator inspection and testing.<br>H and LTC facility] must<br>ergency power system<br>n, and [maintenance]<br>nd in the Health Care<br>FPA 110, and Life Safety<br>3.73(e)(3), §485.625(e)(3)<br>ator fuel. [Hospitals, CAHs<br>that maintain an onsite fuel<br>mergency generators must<br>w it will keep emergency<br>perational during the | TAG  | CROSS-REFERENCED TO THE AI<br>DEFICIENCY)  | PROPRIATE                                   | DATE             |
|                   | this material at NA<br>go to:<br>http://www.archive<br>_of_federal_regul<br>If any changes in  | mation on the availability of<br>ARA, call 202-741-6030, or<br>es.gov/federal_register/code<br>ations/ibr_locations.html.<br>this edition of the Code are<br>eference, CMS will publish a  |  |  |   |                  |

PRINTED: 02/10/2023 FORM APPROVED

| STATEME | NT OF DEFICIENCIES                | X1) PROVIDER/SUPPLIER/CLIA       | (X2) MULTIPLE C | CONSTRUCTION   | OMB NO. 0938-03<br>(X3) DATE SURVEY |          |
|---------|-----------------------------------|----------------------------------|-----------------|--|-------------------------------------|----------|
|         | OF CORRECTION                     | IDENTIFICATION NUMBER            | A. BUILDING     |  | COMPI                               |          |
|         |                                   | 155053                           | B. WING         |  | 01/11/2023                          |          |
| NAME OF | PROVIDER OR SUPPLIEF              | <br>{                            |                 | ADDRESS, CITY, STATE, ZIP COD  |                                     |          |
| WATER   | S OF RUSHVILLE S                  | KILLED NURSING FACILITY, T       |                 | 11TH ST<br>IVILLE, IN 46173  |                                     |          |
| (X4) ID | SUMMARY                           | STATEMENT OF DEFICIENCIE         | ID              | PROVIDER'S PLAN OF CORRECTION  |                                     | (X5)     |
| PREFIX  | (EACH DEFICIEN                    | CY MUST BE PRECEDED BY FULL      | PREFIX          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR |                                     | COMPLETI |
| TAG     | REGULATORY OF                     | R LSC IDENTIFYING INFORMATION    | TAG             | DEFICIENCY)  |                                     | DATE     |
|         | document in the F                 | ederal Register to               |                 |  |                                     |          |
|         | announce the cha                  | nges.                            |                 |  |                                     |          |
|         | (1) National Fire F               | Protection Association, 1        |                 |  |                                     |          |
|         | Batterymarch Par                  | k,                               |                 |  |                                     |          |
|         | Quincy, MA 0216                   | 9, www.nfpa.org,                 |                 |  |                                     |          |
|         | 1.617.770.3000.                   |                                  |                 |  |                                     |          |
|         | .,                                | th Care Facilities Code,         |                 |  |                                     |          |
|         |                                   | ed August 11, 2011.              |                 |  |                                     |          |
|         |                                   | im amendment (TIA) 12-2 to       |                 |  |                                     |          |
|         | NFPA 99, issued                   | -                                |                 |  |                                     |          |
|         | (iii) TIA 12-3 to NF<br>2012.     | PA 99, issued August 9,          |                 |  |                                     |          |
|         | (iv) TIA 12-4 to NI<br>2013.      | FPA 99, issued March 7,          |                 |  |                                     |          |
|         | (v) TIA 12-5 to NF 2013.          | PA 99, issued August 1,          |                 |  |                                     |          |
|         | (vi) TIA 12-6 to NI<br>2014.      | FPA 99, issued March 3,          |                 |  |                                     |          |
|         | (vii) NFPA 101, Li                | fe Safety Code, 2012             |                 |  |                                     |          |
|         | edition, issued Au                | •                                |                 |  |                                     |          |
|         | (VIII) TIA 12-1 to N<br>11, 2011. | IFPA 101, issued August          |                 |  |                                     |          |
|         |                                   | FPA 101, issued October          |                 |  |                                     |          |
|         |                                   | PA 101, issued October           |                 |  |                                     |          |
|         |                                   | FPA 101, issued October          |                 |  |                                     |          |
|         |                                   | tandard for Emergency and        |                 |  |                                     |          |
|         |                                   | stems, 2010 edition,             |                 |  |                                     |          |
|         |                                   | chapter 7, issued August 6,      |                 |  |                                     |          |
|         | 2009                              | . ,                              |                 |  |                                     |          |
|         |                                   | view and interview, the facility | E 0041          | E041– It is the intent of the fa                                     | acility                             | 02/02/2  |
|         |                                   | the emergency power system       | -               | to ensure to implement the   | -                                   |          |
|         | inspection, testing,              | and maintenance requirements     |                 | emergency power system   |                                     |          |
|         | found in the Health               | Care Facilities Code, NFPA       |                 | inspection, testing and  |                                     |          |
|         |                                   | y Code in accordance with 42     |                 | maintenance requirements for   | ound                                |          |
|         |                                   | This deficient practice could    |                 | in the Health Care Facilities  | Code,                               |          |
|         | affect all occupants              |                                  |                 | NFPA 110 and Life Safety C<br>accordance with 42 CFR 483             |                                     |          |

|                   | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING |  |   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|-------------------|--|--|--|--|---|---|--|
|                   | PROVIDER OR SUPPLIEI<br>S OF RUSHVILLE S   | SKILLED NURSING FACILITY, T  | 612 E <sup>-</sup>                         | address, city, state, zip coi<br>11TH ST<br>/ILLE, IN 46173  | )   |   |  |
| (X4) ID<br>PREFIX |  | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL   | ID<br>PREFIX                               | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP   | JLD BE  | (X5)<br>COMPLET                             |  |
| TAG               | Findings include:<br>Based on record rev<br>Executive Director<br>and 1:20 p.m., no d<br>review to show the<br>was exercised at lea<br>minimum of 30 min<br>tests were also miss<br>the time of record r<br>the time stated it was<br>generator tests and<br>done, but the facilit<br>maintenance profes<br>showing current test | A LSC IDENTIFYING INFORMATION<br>view and interview with the<br>on 1/11/23 between 1:15 a.m.<br>occumentation was available for<br>diesel generator set in service<br>ast once monthly, for a<br>nutes since 10-3-22. Weekly<br>sing. Based on an interview at<br>eview, the Executive Director at<br>as her belief that the monthly<br>the weekly tests were being<br>ty was currently without a<br>ssional and no documentation<br>sting could be located.<br>Exhowledged by the Executive<br>of discovery and again at the<br>E:45 p.m. | TAG  | (2) to meet set standards<br>1. CORRECTIVE AC<br>TAKEN:<br>a. On 01/27/2023 the<br>Maintenance Supervisor<br>conducted the monthly g<br>testing for a minimum of<br>minutes and conducted to<br>weekly test and document<br>results in the facilities Lift<br>Binder to meet set stand<br>2. ALL OTHERS WIT<br>POTENTIAL TO BE AFF<br>a. All residents and a<br>and visitors have the pott<br>be affected but none wer<br>3. MEASURES TO P<br>REOCCURRENCE:<br>a. On 01/30/2023 the<br>Administrator in serviced<br>Maintenance Supervisor,<br>on the requirement that a<br>generator test must be co<br>for a minimum of 30 minut<br>with the weekly tests and<br>documented in the facilitit<br>Safety Binder to meet set<br>standards.<br>b. The Maintenance<br>Supervisor/designee will<br>monthly 30 minute at mini-<br>generator test is conduct<br>with the weekly generator<br>and documented in the libinder to meet set standards.<br>b. The Administrator<br>monitor adherence to the<br>Emergency Preparedness<br>Manual and validate the<br>documentation is in place | s.<br>TIONS<br>e enerator<br>30<br>he<br>nted the<br>e Safety<br>ards.<br>TH<br>ECTED:<br>Ill staff<br>ential to<br>re.<br><b>REVENT</b><br>e the<br>(designee<br>a monthly<br>onducted<br>utes along<br>d<br>ies Life<br>it<br>ensure a<br>nimum<br>red along<br>or tests<br>fe safety<br>ards.<br>Will<br>e ss Policy | DATE  |  |

|                   | R MEDICARE & MEDI                   |   | -                                       |  | -  | 3 NO. 0938-039     |
|-------------------|-------------------------------------|---|---|--|--|--------------------|
|                   | VT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053 | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023                              |                    |
|                   | PROVIDER OR SUPPLIE                 | R<br>SKILLED NURSING FACILITY, T                              | 612 E                                   | t address, city, state, zip cod<br>: 11TH ST<br>IVILLE, IN 46173   |  |                    |
| (X4) ID<br>PREFIX | SUMMARY                             | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL    | ID<br>PREFIX                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA  | TE   | (X5)<br>COMPLETION |
| TAG               | REGULATORY C                        | R LSC IDENTIFYING INFORMATION                                 | TAG                                     | 4. MONITORING<br>CORRECTIVE ACTION:<br>a. At least annually to ensu-<br>compliance, the Administrator<br>Maintenance Supervisor/desig<br>will review the Emergency<br>Preparedness Policy Manual a<br>make changes as necessary to<br>meet set standards. Those<br>reviews will be documented as<br>appropriate. The Administrator<br>present the training results at a<br>Quality Assurance/ Performan<br>Improvement (QA/PI) meeting<br>Results and system component<br>will be reviewed by the QA/PI<br>Committee with subsequent pl<br>of correction developed and<br>implemented as deemed<br>necessary to ensure compliant<br>is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance with<br>all regulatory requirements.<br>Our date of compliance is<br>02/02/2023. | and<br>inee<br>and<br>o<br>s<br>r will<br>the<br>ce<br>nts<br>lans<br>ce | DATE               |
| K 0000            |                                     |   |   |  |  |                    |
| Bldg. 01          | Licensure Survey                    | 000018  | K 0000                                  | DISCLAIMER STATEMENT:<br>Preparation and/or execution<br>of this plan of correction in<br>general, or this corrective<br>action in particular, does not<br>constitute an admission or<br>agreement by this facility of<br>facts alleged or conclusions<br>forth in this statement of   | the  |                    |

|                   | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053   | r í | JILDING      | ONSTRUCTION 01  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |                    |
|-------------------|--|---|-----|--------------|---|---|--------------------|
|                   | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T  | THE | 612 E        | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173   |   |                    |
| (X4) ID<br>PREFIX | SUMMARY<br>(EACH DEFICIE   | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL  |     | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | DN<br>BE<br>PRIATE                          | (X5)<br>COMPLETION |
| TAG               | AIM Number: 100<br>At this Life Safety<br>Rushville Skilled I<br>in compliance with<br>in Medicare/Media<br>Life Safety from F<br>National Fire Prote<br>Life Safety Code (<br>Health Care Occup<br>This one-story fac<br>Type V (000) cons<br>The facility has a f<br>detection in the co<br>corridors and batte<br>all resident sleepir<br>portion of the facil<br>a census of 46 at th<br>All areas where re<br>were sprinkled and<br>services were sprin<br>detached wooden s<br>not sprinkled.<br>Quality Review co | R LSC IDENTIFYING INFORMATION         0273930         Code survey, The Waters of         Nursing Facility was found not         a Requirements for Participation         caid, 42 CFR Subpart 483.90(a),         The and the 2012 edition of the         ection Association (NFPA) 101,         LSC), Chapter 19, Existing         pancies and 410 IAC 16.2.         allity was determined to be of         struction and fully sprinklered.         The alarm system with smoke         rridors, spaces open to the         ery-operated smoke detectors in         ig rooms. The healthcare         ity has a capacity of 98 and had         he time of this visit.         sidents have customary access         all areas providing facility         hklered. The facility had two         storage buildings which were |     | TAG          | deficiencies. The plan of<br>correction and specific<br>corrective actions are pre<br>and/or executed in compl<br>with state and federal law<br>This plan of correction<br>constitutes a written alleg<br>of substantial compliance<br>Federal Medicare and<br>Medicaid requirements. | iance<br>s.<br>ation                        | DATE               |
| SS=F<br>Bldg. 01  | Care Facilities<br>Sections of healt<br>other occupancie   | ncies<br>ncies - Sections of Health<br>h care facilities classified as<br>es meet all of the following:<br>ntended to serve four or   |     |              |   |   |                    |
|                   | treatment, or cus  | arated from areas of health   |     |              |   |   |                    |

|         | NT OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053   | R A. BUILDING <u>01</u><br>B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023       |  |
|---------|---|---|------------------------------------|---|---|--|
|         | PROVIDER OR SUPPLIEI  | R<br>SKILLED NURSING FACILITY, T  | 612 E                              | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173   |   |  |
| (X4) ID |   | STATEMENT OF DEFICIENCIE  |                                    |   | (X5)  |  |
| PREFIX  |   | VCY MUST BE PRECEDED BY FULL  | PREFIX                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE   |   |  |
| TAG     | ,   | R LSC IDENTIFYING INFORMATION   | TAG                                | CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | DATE  |  |
|         | fire resistance rati<br>accordance wi<br>o The entire buil<br>by an approved, s<br>automatic sprin<br>with Section 9.7.<br>Hospital outpatien<br>required to be cla<br>Health Care Occu<br>number of patient<br>19.1.3.3, 42 CFR<br>Based on observati<br>failed to ensure 2 o<br>limit the spread of i<br>of smoke. LSC 19.<br>facilities to be main<br>minimize the possil<br>requiring the evacu<br>8.3.4.1 states every<br>be protected to limit<br>the movement of sr<br>barrier to the other.<br>affect all residents.<br>Findings include:<br>Based on observati<br>tour of the facility of<br>1/11/23 between 1:<br>double fire barrier of<br>nursing from the A<br>near Resident Roor<br>Breezeway, did not<br>Director agreed the<br>have latching hardw<br>This finding was action | th Chapter 8.<br>ding is protected throughout<br>supervised<br>inkler system in accordance<br>at surgical departments are<br>ssified as an Ambulatory<br>upancy regardless of the<br>is served.<br>482.41, 42 CFR 485.623<br>on and interview, the facility<br>f 2 separation fire doors would<br>fire and restrict the movement<br>1.1.3 requires all health care<br>intained and operated to<br>bility of a fire emergency<br>ation of the occupants. LSC<br>opening in a fire barrier shall<br>it the spread of fire and restrict<br>moke from one side of the fire<br>This deficient practice could<br>ons and interviews during a<br>with the Executive Director on<br>15 p.m. and 4:00 p.m., the set of<br>doors separating the Skilled<br>ssisted Living occupancies,<br>ns #60 and 61, near the<br>close and latch. The Executive<br>aforementioned doors did not | K 0131                             | <ul> <li>K131– It is the intent of the facilit to ensure separation fire doors would limit the spread of fire and restrict the movement of smoke meet set standards.</li> <li>1. CORRECTIVE ACTIONS TAKEN: <ul> <li>a. The Maintenance</li> <li>Supervisor/designee will repair the set of double fire barrier door separating the Skilled nursing for the Assisted Living occupancies near resident rooms #60 &amp; 61, near the breezeway to meet set standards by 02/16/2023. The Administrator will verify upon completion.</li> <li>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 a doors and found no other negatifindings.</li> </ul> </li> </ul> | d<br>to<br>he<br>on<br>rs<br>om<br>s,<br>om<br>s, |  |

PRINTED: 02/10/2023 FORM APPROVED

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

|                          | NT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053                             | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING | 0NSTRUCTION<br>01   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |
|--------------------------|-------------------------------------|---|---|---|---|
|                          | PROVIDER OR SUPPLIE                 | R<br>SKILLED NURSING FACILITY, T  | 612 E                                     | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)   | E (X5)<br>COMPLETI<br>DATE  |
|                          | exit conference at 3.1-19(b)        |   |   | 3. MEASURES TO PREVER<br>REOCCURRENCE:<br>a. On 01/30/2023 the<br>Administrator in serviced the<br>Maintenance Supervisor on the<br>requirement to ensure to provide<br>properly rated fire resistive bar<br>and or self-closing and automation<br>latching doors in a fire barrier without<br>to meet set standards.<br>b. Maintenance<br>Supervisor/designee will inspecial<br>doors throughout the facility<br>monthly to ensure they are<br>properly maintained, self-closed<br>and latch fully into frame as a pro-<br>of the facility's Preventive<br>Maintenance Program and<br>document those inspection resisting<br>as appropriate. If any issues as<br>discovered, they will be addressist<br>and resolved immediately. The<br>Maintenance Supervisor/designed<br>will review with the Administration<br>the inspection results.<br>c. The Administrator will<br>monitor adherence to the<br>Preventative Maintenance<br>schedule and validate the<br>Preventative Maintenance<br>documentation is in place.<br>4. MONITORING<br>CORRECTIVE ACTION:<br>a. The inspection results with<br>be presented by the Maintenance<br>Supervisor/designee to the<br>Administrator will present the<br>inspection results at the monthol<br>Quality Assurance/Performance | NT<br>e<br>de<br>riers<br>stic<br>vall<br>ct<br>bart<br>ults<br>are<br>ssed<br>e<br>nee<br>or<br>ill<br>hce |

|                            | R MEDICARE & MEDIC   |   |  | <b>-</b>   | OMB NO. 0938-039                            |  |
|----------------------------|--|---|--|--|---|--|
|                            | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|                            | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T  | 612 E  | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173  |   |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY<br>(EACH DEFICIE)  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE                  |  |
|                            |  |   |  | Improvement (QA/PI) meeting.<br>Inspection results and system<br>components will be reviewed by<br>the QA/PI Committee with<br>subsequent plans of correction<br>developed and implemented as<br>deemed necessary to ensure<br>compliance is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance with<br>all regulatory requirements.<br>Our date of compliance is<br>02/16/2023.                               |   |  |
| < 0211<br>SS=E<br>Bldg. 01 | discharges, exit le<br>in accordance wit<br>of egress is conti<br>all obstructions to<br>emergency, unles<br>through 18/19.2.2   | - General<br>ays, corridors, exit<br>ocations, and accesses are<br>h Chapter 7, and the means<br>nuously maintained free of<br>full use in case of<br>as modified by 18/19.2.2<br>1.    |  |  |   |  |
|                            | failed to ensure 1 of<br>were continuously<br>obstructions. LSC<br>into the required w<br>wheeled equipmen<br>following conditio<br>(a) The wheeled ec<br>clear unobstructed<br>in.(1525 mm).<br>(b) The health care<br>training program a | on and interview, the facility<br>f 6 corridor means of egresses<br>maintained free of<br>19.2.3.4 (4) states projections<br>idth shall be permitted for<br>t, provided that all of the | K 0211   | <ul> <li>K211 – It is the intent of the facility to ensure corridor means of egresses are continuously maintained free of obstructions to meet set standards.</li> <li>1. CORRECTIVE ACTIONS TAKEN: <ul> <li>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</li> </ul> </li> </ul> | 02/02/202                                   |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | x1) provider/supplier/clia<br>identification number<br>155053  | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING | ONSTRUCTION <u>01</u>   | COMP  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|--------------------------|--|--|---|---|---|---|--|
|                          | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T   | 612 E                                     | ADDRESS, CITY, STATE, ZIP COI<br>11TH ST<br>VILLE, IN 46173   | D   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE<br>REGULATORY O<br>(c)The wheeled eq<br>following:<br>i. Equipment in us<br>ii. Medical emerge<br>iii. Patient lift and<br>This deficient prace<br>facility.<br>Findings include:<br>Based on observat<br>tour of the facility<br>1/11/23 between 1<br>Resident Room #1<br>Equipment (PPE) o<br>with wheels allow: | A STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br><u>R LSC IDENTIFYING INFORMATION</u><br>uipment is limited to the<br>e and carts in use<br>ency equipment not in use<br>transport equipment<br>tice affects 6 residents in the<br>ions and interviews during a<br>with the Executive Director on<br>:15 p.m. and 4:00 p.m., near<br>2 a Personal Protective<br>cart was in use but not equipped<br>ing the carts to be move out of<br>emergency. Based on an | ID<br>PREFIX<br>TAG                       | PROVIDERS PLAN OF CORRECTIVE ACTION SHOT<br>(EACH CORRECTIVE ACTION SHOT<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)<br>Verified the work on<br>01/11/2023.<br>2. ALL OTHERS WIT<br>POTENTIAL TO BE AFF<br>a. All residents and a<br>and visitors have the pot<br>be affected but none wer<br>01/11/2023 the Maintena<br>Supervisor/designee insp<br>corridor means of egress<br>found no other negative<br>3. MEASURES TO P<br>REOCCURRENCE:<br>a. On 01/30/2023 the<br>Administrator in serviced<br>Maintenance Supervisor,<br>and all other staff on the                   | TH<br>ECTED:<br>all staff<br>cential to<br>re. On<br>ance<br>pected all<br>s and<br>findings.<br>PREVENT  | (X5)<br>COMPLETI<br>DATE                    |  |
|                          | interview at the tim<br>Executive Director<br>equipped with who<br>replaced with a PP<br>This finding was a  | ne of observations, the<br>e stated the PPE cart was not<br>cels and would need to be<br>E cart with wheels.<br>cknowledged by the Executive<br>e of discovery and again at the  |   | requirement that the corr<br>means of egress are to r<br>free of obstructions to me<br>standards.<br>b. Maintenance<br>Supervisor/designee will<br>all corridor means of egr<br>throughout the facility we<br>obstructions as a part of<br>facility's Preventive Main<br>Program and document<br>inspection results as app<br>If any issues are discove<br>will be addressed and re<br>immediately. The Mainte<br>Supervisor/designee will<br>with the Administrator the<br>inspection results.<br>c. The Administrator<br>monitor adherence to the<br>Preventative Maintenance | ridor<br>remain<br>eet set<br>inspect<br>ess<br>eekly for<br>the<br>those<br>propriate.<br>ered, they<br>esolved<br>enance<br>review<br>e<br>will<br>e<br>ce<br>e |   |  |

|                            | NT OF DEFICIENCIES  | x1) provider/supplier/clia<br>identification number<br>155053  | (X2) MULTIPLE (<br>A. BUILDING<br>B. WING | construction <u>01</u>   | СОМ  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|----------------------------|---|--|---|--|--|---|--|
|                            | PROVIDER OR SUPPLIE   | R<br>R<br>SKILLED NURSING FACILITY, T  | 612 E                                     | t address, city, state, zip cc<br>11TH ST<br>WILLE, IN 46173   | DD   |   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | ECTION<br>DULD BE<br>PROPRIATE   | (X5)<br>COMPLETIO<br>DATE                   |  |
| < 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors  |  |   | documentation is in place<br>4. MONITORING<br>CORRECTIVE ACTION<br>a. The inspection re-<br>be presented by the Ma<br>Supervisor/designee to<br>Administrator monthly a<br>Administrator will prese<br>inspection results at the<br>Quality Assurance/Perfor<br>Improvement (QA/PI) m<br>Inspection results and s<br>components will be revi<br>the QA/PI Committee w<br>subsequent plans of con-<br>developed and implement<br>deemed necessary to e<br>compliance is maintaine<br>This plan of correction<br>constitutes our credible<br>allegation of compliance<br>02/02/2023. | :<br>sults will<br>intenance<br>the<br>and the<br>and the<br>anothly<br>ormance<br>beeting.<br>system<br>ewed by<br>ith<br>rrection<br>ented as<br>nsure<br>ed.<br><b>b</b><br>le<br>ce with<br>bents. |   |  |
|                            | be equipped with<br>requires the use<br>egress side unles<br>special locking at<br>CLINICAL NEED<br>LOCKING<br>Where special lo<br>clinical security n<br>used, only one lo<br>permitted on eac | ed means of egress shall not<br>a latch or a lock that<br>of a tool or key from the<br>ss using one of the following<br>rangements:<br>S OR SECURITY THREAT<br>cking arrangements for the<br>eeds of the patient are<br>cking device shall be<br>h door and provisions shall<br>rapid removal of occupants |   |  |  |   |  |

|                   | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | (X2) MULT<br>A. BUILD<br>B. WING |          | nstruction 01  | CO          | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|-------------------|--|--|----------------------------------|----------|--|-------------|---|--|
|                   | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T   | 6                                | 12 E 11  | DDRESS, CITY, STATE, ZIP (<br>TH ST<br>LLE, IN 46173 | COD         |   |  |
| (X4) ID<br>PREFIX |  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL   | II<br>PRF                        | )<br>FIX | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION S   | SHOULD BE   | (X5)<br>COMPLETI                            |  |
| TAG               |  | R LSC IDENTIFYING INFORMATION  |                                  | AG       | CROSS-REFERENCED TO THE<br>DEFICIENCY)               | APPROPRIATE | DATE  |  |
|                   | locks or keys car<br>other such reliab<br>staff at all times.<br>18.2.2.5.1, 18.2<br>19.2.2.6<br>SPECIAL NEEDS<br>ARRANGEMENT<br>Where special lo<br>safety needs of the<br>the Clinical or Se<br>are being met. In<br>electrical locks the<br>release upon loss<br>building is protected<br>detection system<br>at an attended lo<br>space); and both<br>systems are arra<br>upon activation.<br>18.2.2.5.2, 19.2<br>DELAYED-EGRE<br>ARRANGEMENT<br>Approved, listed<br>systems installed<br>7.2.1.6.1 shall be<br>assemblies servi<br>contents in buildi<br>an approved, sup<br>detection system<br>automatic sprinki<br>18.2.2.2.4, 19.2.2<br>ACCESS-CONTI<br>LOCKING ARRA<br>Access-Controlled | TS<br>cking arrangements for the<br>ne patient are used, all of<br>curity Locking requirements<br>addition, the locks must be<br>that fail safely so as to<br>s of power to the device; the<br>ted by a supervised<br>er system and the locked<br>d by a complete smoke<br>(or is constantly monitored<br>cation within the locked<br>the sprinkler and detection<br>nged to unlock the doors<br>2.2.2.5.2, TIA 12-4<br>ESS LOCKING<br>TS<br>delayed-egress locking<br>in accordance with<br>permitted on door<br>ng low and ordinary hazard<br>ngs protected throughout by<br>pervised automatic fire<br>or an approved, supervised<br>er system.<br>2.2.4<br>ROLLED EGRESS<br>NGEMENTS<br>d Egress Door assemblies<br>dance with 7.2.1.6.2 shall |                                  |          |  |             |   |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/11/2023 155053 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 612 E 11TH ST WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE RUSHVILLE, IN 46173 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0222 K222 - It is the intent of the facility 02/02/2023 failed to ensure the means of egress through 1 of to ensure means of egress 1 exits with special locking arrangements for the through exits with special locking clinical security needs of the residents were arrangements for the clinical readily accessible by remote control of locks; keys security needs of the residents are carried by staff at all times; or other such reliable readily accessible by remote means available to the staff at all times. This control of locks, keys carried by deficient practice could affect 25 residents. staff at all times. or other such reliable means available to the Findings include: staff at all times to meet set standards. Based on observations and interviews during a 1. CORRECTIVE ACTIONS tour of the facility with the Executive Director on TAKEN: 1/11/23 between 1:15 p.m. and 4:00 p.m., the exit On 01/11/2023 the а door #10 was locked, could be opened by entering Maintenance Supervisor/designee a four-digit code, but when asked to open the posted information to obtain the door, the staff person did not enter the correct code by the door at exit door #10. code and could not open the door. also all doors will automatically release upon activation of the fire This finding was acknowledged by the Executive alarm system to meet set Director at the time of discovery and again at the standards. The Administrator exit conference at 4:45 p.m. verified the posting of the codes on 01/11/2023. 3.1-19(b) 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: All residents and all staff a. and visitors have the potential to be affected but none were. On 01/30/2023 the Maintenance Supervisor/designee inspected all

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

Event ID:

IMFR21 Facility I

Facility ID: 000018

If continuation sheet

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02/10/2023

PRINTED:

|                   | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053 | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING   | ONSTRUCTION 01  | СОМ  | te survey<br>pleted<br>1/2023 |
|-------------------|------------------------------------|---|---|---|--|-------------------------------|
|                   | ROVIDER OR SUPPLIE                 | R<br>SKILLED NURSING FACILITY, T                              | STREET ADDRESS, CITY, STATE, ZIP COD<br>612 E 11TH ST<br>7, THE RUSHVILLE, IN 46173 |   | D  |                               |
| (X4) ID<br>PREFIX | SUMMARY<br>(EACH DEFICIE           | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL    | ID<br>PREFIX  | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)   | CTION<br>ULD BE<br>PROPRIATE   | (X5)<br>COMPLETI              |
| TAG               | REGULATORY C                       | R LSC IDENTIFYING INFORMATION                                 | TAG   | doors to the means of eacessible for use and for<br>other negative findings.<br>3. <b>MEASURES TOF</b><br><b>REOCCURRENCE:</b><br>a. On 01/30/2023 the<br>Administrator in serviced<br>Maintenance Supervisor<br>on the requirement that<br>must be readily accessible<br>to meet set standards.<br>b. Maintenance<br>Supervisor/designee will<br>all means of egress through<br>facility weekly to ensure<br>readily accessible for use<br>part of the facility's Prev<br>Maintenance Program and<br>document those inspect<br>as appropriate. If any is<br>discovered, they will be<br>and resolved immediate<br>Maintenance Supervisor<br>will review with the Adm<br>the inspection results.<br>c. The Administrator<br>monitor adherence to th<br>Preventative Maintenand<br>schedule and validate th<br>Preventative Maintenand<br>schedule and validate th<br>Preventative Maintenand<br>schedule and validate th<br>Preventative Maintenand<br>accumentation is in place<br>4. <b>MONITORING</b><br><b>CORRECTIVE ACTION:</b><br>a. The inspection results<br>a. The inspection results<br>a. The inspection results<br>a. The inspection results<br>a. The inspection results<br>be presented by the Mai | A prevent<br>PREVENT<br>e<br>d the<br>f/designee<br>doors<br>ble for use<br>l inspect<br>ughout the<br>doors are<br>e as a<br>entive<br>nd<br>ion results<br>ssues are<br>addressed<br>ly. The<br>f/designee<br>inistrator<br>will<br>e<br>ce<br>ble<br>ce<br>the<br>ce<br>the<br>sults will<br>intenance<br>the<br>nd the<br>nd the<br>nt the | DATE                          |

|                            | NT OF DEFICIENCIES<br>OF CORRECTION  | x1) provider/supplier/clia<br>identification number<br>155053                             | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | construction <u>01</u>   | COM  | (3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|----------------------------|--|---|---|--|--|--|--|
|                            | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T  | 612                                     | et address, city, state, zip cod<br>E 11TH ST<br>HVILLE, IN 46173  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | TION<br>LD BE<br>COPRIATE  | (X5)<br>COMPLETION<br>DATE                 |  |
|                            |  |   |   | Quality Assurance/Perform<br>Improvement (QA/PI) mean<br>Inspection results and syst<br>components will be review<br>the QA/PI Committee with<br>subsequent plans of correct<br>developed and implement<br>deemed necessary to ensist<br>compliance is maintained<br>This plan of correction<br>constitutes our credible<br>allegation of compliance<br>all regulatory requirement<br>Our date of compliance in<br>02/02/2023. | eting.<br>stem<br>ved by<br>bection<br>ted as<br>sure<br>•<br>• with<br>nts. |  |  |
| < 0300<br>SS=F<br>Bldg. 01 | Section 18.3 and<br>requirements tha<br>provided K-tags,<br>information, along<br>Safety Code or N<br>should be include<br>Based on record re<br>observation, the fa<br>documentation for<br>of battery-operated<br>rooms was comple<br>existing life safety<br>if not required by t<br>NFPA 72, 29.10 M<br>Fire-warning equip<br>tested in accordance<br>published instructio<br>of Chapter 14. NFJ<br>testing, and maintee | r<br>RKS section any LSC  | K 0300                                  | <ul> <li>K300– It is the intent of the to ensure documentation preventative maintenance battery-operated smoke a resident rooms is complete meet set standards.</li> <li>1) CORRECTIVE ACT TAKEN: <ul> <li>a) On 01/30/2023 the Maintenance Supervisor/or replaced the batteries in the smoke detector that had be that expired on 1/1/23 and documented the informatical standards.</li> </ul> </li> </ul>                    | for the<br>of<br>larms in<br>te to<br>IONS<br>designee<br>he<br>patteries    | 02/02/202                                  |  |

|                                     | OMB NO. 0938-03 |
|-------------------------------------|-----------------|
| . ,                                 | DATE SURVEY     |
| COMPLETED                           |                 |
| 01                                  | 1/11/2023       |
| ZIP COD                             |                 |
|                                     |                 |
|                                     |                 |
| OF CORRECTION                       | (X5)            |
| TION SHOULD BE<br>D THE APPROPRIATE | COMPLETI        |
| CY)                                 | DATE            |
| Smoke Detector                      |                 |
| to meet set                         |                 |
| dministrator                        |                 |
| n                                   |                 |
|                                     |                 |
| S WITH                              |                 |
|                                     |                 |
| s and all staff                     |                 |
| the potential to                    |                 |
| ne were.                            |                 |
| TO PREVENT                          |                 |
|                                     |                 |
|                                     |                 |
| 023 the                             |                 |
| erviced the                         |                 |
| ervisor/designee                    |                 |
| t that battery                      |                 |
| larms must be                       |                 |
| anufacture's                        |                 |
| cumentation                         |                 |
| ility to meet set                   |                 |
|                                     |                 |
| 9                                   |                 |
| ee will ensure                      |                 |
| ed smoke                            |                 |
| ntained per                         |                 |
| lelines and                         |                 |
| ults on the                         |                 |
| Smoke Detector                      |                 |
| to be filed in the                  |                 |
| as a part of the                    |                 |
|                                     |                 |
| e Maintenance                       |                 |
| ssues are                           |                 |
| vill be addressed                   |                 |
| ediately. The                       |                 |
| ervisor/designee                    |                 |
| e Administrator                     |                 |
| ults.                               |                 |
| strator will                        |                 |
| e to the                            |                 |
| tenance                             |                 |
| e<br>t                              | to the          |

|                            | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053                             | (X2) MUL'<br>A. BUIL<br>B. WINC | DING              | nstruction <u>01</u>  | COM   | te survey<br>ipleted<br>1/2023 |
|----------------------------|--|---|---------------------------------|-------------------|---|---|--------------------------------|
|                            | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, 1  | 6                               | 612 E 1           | ADDRESS, CITY, STATE, ZIP COE<br>1TH ST<br>'ILLE, IN 46173  | )   |                                |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PR                              | ID<br>EFIX<br>FAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)<br>schedule and validate the<br>Preventative Maintenanc<br>documentation is in place<br>4) MONITORING<br>CORRECTIVE ACTION:<br>a) The inspection res   | ILD BE<br>ROPRIATE  | (X5)<br>COMPLETION<br>DATE     |
|                            |  |   |                                 |                   | be presented by the Mair<br>Supervisor/designee to the<br>Administrator monthly and<br>Administrator will present<br>inspection results at the re-<br>Quality Assurance/Perfor<br>Improvement (QA/PI) me<br>Inspection results and sy<br>components will be reviet<br>the QA/PI Committee with<br>subsequent plans of corre-<br>developed and implement<br>deemed necessary to en-<br>compliance is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance<br>all regulatory requirement<br>Our date of compliance<br>02/02/2023. | ne<br>d the<br>t the<br>monthly<br>mance<br>eeting.<br>stem<br>wed by<br>h<br>ection<br>ted as<br>sure<br>d.<br>e with<br>ents. |                                |
| K 0341<br>SS=F<br>Bldg. 01 | and components<br>accordance with<br>Code, and NFPA<br>Code to provide<br>part of the buildir<br>occupied, detecti<br>alarm control uni<br>detection is also |   |                                 |                   |   |   |                                |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/11/2023 155053 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 612 E 11TH ST WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE RUSHVILLE, IN 46173 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0341 K341 – It is the intent of the 02/02/2023 failed to ensure 1 of 1 fire alarm control panels was facility to ensure fire alarm control protected. NFPA 72, National Fire Alarm and panels are protected to meet set Signaling Code Section 10.10.1 states a means for standards. turning off activated alarm notification 1. **CORRECTIVE ACTIONS** appliance(s) shall be permitted only if it complies TAKEN: with 10.10.3 through 10.10.7. Section 10.10.3 states a. On 01/11/2023 the the means shall be key-operated or located within Maintenance Supervisor/designee a locked cabinet or arranged to provide equivalent removed the key that was in the protection against unauthorized use. This FACP door and locked the door to deficient practice could affect all occupants. meet set standards. The Administrator verified the work on 01/11/2023. Findings include: ALL OTHERS WITH 2. Based on observations and interviews during a POTENTIAL TO BE AFFECTED: tour of the facility with the Executive Director on a. All residents and all staff 1/11/23 between 1:15 p.m. and 4:00 p.m., the fire and visitors have the potential to alarm control panel (FACP) door was not locked, be affected but none were. On and the key was in the FACP door. The FACP is 01/12/2023 the Maintenance located in a high traffic area in the main corridor Supervisor/designee inspected all near the entrance to the facility. other areas and found no other negative findings. This finding was acknowledged by the Executive MEASURES TO PREVENT 3. Director at the time of discovery and again at the REOCCURRENCE: exit conference at 4:45 p.m. a. On 01/30/2023 the Administrator in serviced the 3.1-19(b) 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 IMFR21

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

Event ID:

Facility ID: 000018

If continuation sheet

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02/10/2023

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| TATEMEN | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CO           | ONSTRUCTION   | (X3) DATE SURVEY |
|---------|---------------------|-------------------------------|----------------------------|---|------------------|
| ND PLAN | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BUILDING                | 01  | COMPLETED        |
|         |                     | 155053                        | B. WING                    |   | 01/11/2023       |
|         |                     | D                             | STREET A                   | ADDRESS, CITY, STATE, ZIP COD   |                  |
|         | PROVIDER OR SUPPLIE |                               |                            | 11TH ST   |                  |
| VATERS  | S OF RUSHVILLE      | SKILLED NURSING FACILITY, T   | HE RUSH                    | /ILLE, IN 46173   |                  |
| X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE      | ID                         | PROVIDER'S PLAN OF CORRECTION   | (X5)             |
| REFIX   | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL  | PREFIX                     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | COMPLETION       |
| TAG     | REGULATORY O        | R LSC IDENTIFYING INFORMATION | TAG                        | DEFICIENCY)   | DATE             |
|         |                     |                               |                            | locked as a part of the facility's                                      |                  |
|         |                     |                               |                            | Preventive Maintenance Progra   |                  |
|         |                     |                               |                            | and document those inspectior   | 1                |
|         |                     |                               |                            | results as appropriate. If any  |                  |
|         |                     |                               |                            | issues are discovered, they wil   | lbe              |
|         |                     |                               |                            | addressed and resolved  |                  |
|         |                     |                               |                            | immediately. The Maintenance  |                  |
|         |                     |                               |                            | Supervisor/designee will review   | v                |
|         |                     |                               | 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   |                  |
|         |                     |                               |                            |   | :11              |
|         |                     |                               |                            | a. The inspection results w   |                  |
|         |                     |                               |                            | be presented by the Maintenar   | ice              |
|         |                     |                               |                            | Supervisor/designee to the  |                  |
|         |                     |                               |                            | Administrator monthly and the   |                  |
|         |                     |                               |                            | Administrator will present the  | h.               |
|         |                     |                               |                            | inspection results at the month<br>Quality Assurance/Performanc         | -                |
|         |                     |                               |                            | Improvement (QA/PI) meeting.  |                  |
|         |                     |                               |                            | Inspection results and system   |                  |
|         |                     |                               |                            | components will be reviewed b   | N/               |
|         |                     |                               |                            | the QA/PI Committee with  | y                |
|         |                     |                               |                            | 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.   |                  |
|         |                     |                               |                            |   |                  |

|                            | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | CONSTRUCTION <u>01</u>   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |                          |
|----------------------------|--|--|---|--|---|--------------------------|
| WATER                      |  | R<br>SKILLED NURSING FACILITY, T   | 612 E                                   | T ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>IVILLE, IN 46173   |   | (¥5)                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE  | NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | PREFIX<br>TAG                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | ATE CO  | (X5)<br>OMPLETIO<br>DATE |
| < 0353<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System<br>Sprinkler System<br>Automatic sprink<br>are inspected, te<br>accordance with<br>Inspection, Testin<br>Water-based Fire<br>Records of syste<br>inspection and te<br>secure location a<br>a) Date sprinkle<br>b) Who provide<br>c) Water system<br>Provide in REMA<br>coverage for any<br>automatic sprinkl<br>9.7.5, 9.7.7, 9.7.6<br>1. Based on observ<br>failed to ensure sp<br>were not loaded or<br>in accordance with<br>edition, at 5.2.1.1.<br>of leakage; shall b<br>materials, paint, ar<br>be installed in the<br>up-right, pendent,<br>5.2.1.1.2 any sprin<br>the following shall<br>Corrosion (3) Phys<br>the glass bulb heat<br>Loading (6) Painti | <ul> <li>Maintenance and Testing</li> <li>Maintenance and Testing</li> <li>Ier and standpipe systems</li> <li>sted, and maintained in</li> <li>NFPA 25, Standard for the</li> <li>ng, and Maintaining of</li> <li>Protection Systems.</li> <li>m design, maintenance,</li> <li>esting are maintained in a</li> <li>and readily available.</li> <li>er system last checked</li> <li>d system test</li> <li>n supply source</li> <li>NRKS information on</li> <li>non-required or partial</li> <li>er system.</li> <li>and NFPA 25</li> <li>vation and interview, the facility</li> <li>rinkler heads in the laundry area</li> <li>covered with foreign material</li> <li>a LSC 9.7.5. NFPA 25, 2011</li> <li>1 sprinklers shall not show signs</li> <li>e free of corrosion, foreign</li> <li>nd physical damage; and shall</li> <li>correct orientation (e.g.,</li> <li>or sidewall). Furthermore, at</li> <li>kler that shows signs of any of</li> <li>be replaced: (1) Leakage (2)</li> <li>sical Damage (4) Loss of fluid in</li> <li>responsive element (5)</li> <li>ng unless painted by the</li> <li>turer. This deficient practice</li> </ul> | K 0353                                  | K353 – It is the intent of the<br>facility to ensure sprinkler hea<br>in the laundry area are not loo<br>or covered with foreign mater<br>accordance with LSC 9.7.5 a<br>ensure sprinkler systems are<br>provided with spare sprinkler:<br>spare sprinkler cabinet and a<br>sprinkler wrench on the prem<br>to meet set standards.<br><b>1.CORRECTIVE ACTIONS</b><br><b>TAKEN:</b><br>1.On 01/30/2023 a Licer<br>Sprinkler Contractor/Mainten:<br>Supervisor/designee repaired<br>two sprinkler heads in the lau<br>that were covered in dust or<br>showed signs of loading to m | ads<br>aded<br>ial in<br>nd to<br>s, a<br>ises<br>ises<br>hsed<br>ance<br>I the<br>ndry | 2/16/202                 |

| STATEME | R MEDICARE & MEDIC  | X1) PROVIDER/SUPPLIER/CLIA        | (X2) MULTIPLE C | ONSTRUCTION  | (3) DATE SURVEY |  |
|---------|---|-----------------------------------|-----------------|--|-----------------|--|
|         | OF CORRECTION   | IDENTIFICATION NUMBER             | A. BUILDING     | <u>01</u>  | COMPLETED       |  |
|         |   | 155053                            | B. WING         | <u> </u>   | 01/11/2023      |  |
|         | PROVIDER OR SUPPLIE   |                                   | 612 E           | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST                                 |                 |  |
| WATERS  | S OF RUSHVILLE S  | SKILLED NURSING FACILITY, TH      | IE RUSH         | VILLE, IN 46173  |                 |  |
| X4) ID  | SUMMARY   | STATEMENT OF DEFICIENCIE          | ID              | PROVIDER'S PLAN OF CORRECTION  | (X5)            |  |
| REFIX   | (EACH DEFICIE)  | NCY MUST BE PRECEDED BY FULL      | PREFIX          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE | COMPLETION      |  |
| TAG     |   | R LSC IDENTIFYING INFORMATION     | TAG             | DEFICIENCY)  | DATE            |  |
|         |   | ons and interviews during a       |                 | set standards. The Administrate  | or              |  |
|         | -   | with the Executive Director on    |                 | verified the work on 02/02/2023  |                 |  |
|         |   | 15 p.m. and 4:00 p.m., 2 of 4     |                 | 2. The Licensed Sprinkler  |                 |  |
|         | sprinkler heads in t  | he laundry were coved in dust     |                 | Contractor/Maintenance   |                 |  |
|         | or showed signs of  | loading.                          |                 | Supervisor/designee will install a                                       | a               |  |
|         |   |                                   |                 | second sprinkler cabinet so eac  | h               |  |
|         | -   | cknowledged by the Executive      |                 | sprinkler would have it's own  |                 |  |
|         | Director at the time  | e of discovery and again at the   |                 | protected slot and will ensure th  | e               |  |
|         | exit conference at  | 4:45 p.m.                         |                 | additional spare sprinkler heads   |                 |  |
|         |   |                                   |                 | are new and meet set standards   | ;               |  |
|         | 2. Based on observ  | ation and interview, the facility |                 | by 02/16/2023. The Administrat   | or              |  |
|         | failed to ensure 1 c  | f 1 sprinkler systems were        |                 | will verify the work upon  |                 |  |
|         | provided with spar  | e sprinklers, a spare sprinkler   |                 | completion.  |                 |  |
|         | cabinet and a sprin   | kler wrench on the premises.      |                 | 2.ALL OTHERS WITH  |                 |  |
|         | NFPA 25, Standard   | d for the Inspection, Testing,    |                 | POTENTIAL TO BE AFFECTED   | ):              |  |
|         | and Maintenance of  | f Water-Based Fire Protection     |                 | 1.All residents and all staff  |                 |  |
|         | Systems, 2011 Edi   | tion, Section 5.4.1.4 states a    |                 | and visitors have the potential to                                       |                 |  |
|         | supply of spare spr   | inklers (never fewer than six)    |                 | be affected but none were.   |                 |  |
|         | shall be maintained   | d on the premises so that any     |                 | 3.MEASURES TO PREVENT  |                 |  |
|         | sprinklers that have  | e been operated or damaged in     |                 | REOCCURRENCE:  |                 |  |
|         | any way can be pro  | omptly replaced. The sprinklers   |                 | 1.On 01/30/2023 the  |                 |  |
|         | shall correspond to   | the types and temperature         |                 | Administrator in serviced the  |                 |  |
|         | ratings of the sprin  | klers on the property. The        |                 | Maintenance Supervisor/design  | ee              |  |
|         | sprinklers shall be   | kept in a cabinet located where   |                 | on the requirement that the  |                 |  |
|         | the temperature in  | which they are subjected will at  |                 | sprinkler system must be proper  | ly              |  |
|         |   | ) degrees Fahrenheit. A special   |                 | maintained to meet set standard  |                 |  |
|         | sprinkler wrench s  | hall be provided and kept in the  |                 | 2.Maintenance  |                 |  |
|         | cabinet to be used  | in the removal and installation   |                 | Supervisor/designee will ensure  |                 |  |
|         | of sprinklers. This   | deficient practice could affect   |                 | the sprinkler systems are provid   |                 |  |
|         | all residents and st  |                                   |                 | with spare sprinkler heads   |                 |  |
|         |   |                                   |                 | secured in their own protective  |                 |  |
|         | Findings include:   |                                   |                 | slots as a part of the facility's  |                 |  |
|         |   |                                   |                 | Preventive Maintenance Progra  | m               |  |
|         | Based on observati  | ons and interviews during a       |                 | and document those inspection  |                 |  |
|         |   | with the Executive Director on    |                 | results as appropriate. If any   |                 |  |
|         |   | 15 p.m. and 4:00 p.m., there was  |                 | issues are discovered, they will   | be              |  |
|         |   | cabinet in the riser room that    |                 | addressed and resolved   |                 |  |
|         |   | prinklers; 4 of which were not    |                 | immediately. The Maintenance   |                 |  |
|         |   |                                   |                 | Supervisor/designee will review  |                 |  |
|         | in their own protected slot. They were stored<br>loose in the cabinet and not secured in holders, 4 |                                   | 1               |  | 1               |  |

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

Event ID: IMFR21 Facility ID: 000018

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CENTERS FOR MEDICARE & MEDICAID SERVICES

| PRINTED:        | 02/10/2023 |
|-----------------|------------|
| FORM AP         | PROVED     |
| OMB NO.         | 0938-039   |
| (X3) DATE SURVE | Y          |
| COMPLETED       |            |
|                 |            |

| AND PLAN                   | OF CORRECTION   | IDENTIFICATION NUMBER 155053  | A. BUILDING <u>01</u><br>B. WING |   | COMPLETED 01/11/2023         |  |
|----------------------------|---|---|----------------------------------|---|------------------------------|--|
|                            | PROVIDER OR SUPPLIE   | R<br>SKILLED NURSING FACILITY, T  | 612 E                            | t address, city, state, zip cod<br>11TH ST<br>IVILLE, IN 46173  |                              |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE)  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)   | E (X5)<br>COMPLETION<br>DATE |  |
| 14 0262                    | previous installation<br>new.<br>This finding was an<br>Director at the time<br>exit conference at 4<br>3.1-19(b) | rinkler heads showed signs of<br>n and did not appear to be<br>eknowledged by the Executive<br>of discovery and again at the<br>4:45 p.m.                               |                                  | inspection results.<br>3. The Administrator will<br>monitor adherence to the<br>Preventative Maintenance<br>schedule and validate the<br>Preventative Maintenance<br>documentation is in place.<br>4.MONITORING CORRECTIV<br>ACTION:<br>1. The inspection results w<br>be presented by the Maintenan<br>Supervisor/designee to the<br>Administrator monthly and the<br>Administrator will present the<br>inspection results at the monthl<br>Quality Assurance/Performance<br>Improvement (QA/PI) meeting.<br>Inspection results and system<br>components will be reviewed b<br>the QA/PI Committee with<br>subsequent plans of correction<br>developed and implemented as<br>deemed necessary to ensure<br>compliance is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance with<br>all regulatory requirements.<br>Our date of compliance is<br>02/16/2023. | rill<br>lice<br>ly<br>e<br>y |  |
| K 0363<br>SS=E<br>Bldg. 01 | than required end<br>exits, or hazardou<br>of smoke and are<br>solid-bonded core                                  | corridor openings in other<br>losures of vertical openings,<br>us areas resist the passage<br>made of 1 3/4 inch<br>e wood or other material<br>ng fire for at least 20 |                                  |   |                              |  |

|  | MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AN OF CORRECTION IDENTIFICATION NUMBER<br>155053   |   | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING                 | <u>01</u>   | OMB NO. 0938-0:<br>(X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|--|---|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER<br>WATERS OF RUSHVILLE SKILLED NURSING FACILITY, TH |   | 612 E 1   | ADDRESS, CITY, STATE, ZIP COD<br>1TH ST<br>/ILLE, IN 46173 |   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE)  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETH<br>DATE                                       |  |
|  | compartments ar<br>passage of smok<br>to rooms containi<br>combustible mate<br>hardware. Roller<br>CMS regulation.<br>apply to auxiliary<br>flammable or com<br>Clearance betwe<br>covering is not ex<br>doors complying<br>if provided with a<br>the door closed w<br>applied. There is<br>closing of the door<br>release when the<br>permitted. Nonrat<br>unlimited height a<br>meeting 19.3.6.3<br>frames shall be la<br>other materials in<br>unless the smoke<br>sprinklered. Fixed<br>allowed per 8.3. I<br>there are no restr<br>resistance of glas<br>assemblies.<br>19.3.6.3, 42 CFR<br>483, and 485<br>Show in REMARI<br>fire protection rat<br>devices, etc.<br>1. Based on observ<br>failed to ensure 2 of<br>impediment to close<br>frame and would restricts. | rials have positive latching<br>latches are prohibited by<br>These requirements do not<br>spaces that do not contain<br>nbustible material.<br>en bottom of door and floor<br>ceeding 1 inch. Powered<br>with 7.2.1.9 are permissible<br>device capable of keeping<br>when a force of 5 lbf is<br>no impediment to the<br>brs. Hold open devices that<br>door is pushed or pulled are<br>ted protective plates of<br>are permitted. Dutch doors<br>6 are permitted. Door<br>abeled and made of steel or<br>compliance with 8.3, | K 0363   | K363 – It is the intent of the<br>facility to ensure corridor doors<br>have no impediment to closing<br>latching into the door frame and<br>would resist the passage of<br>smoke to meet set standards. | and  |  |

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| STATEME                | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA          | (X2) MULTIPLE C               |   | X3) DATE SURVEY         |
|------------------------|--|-------------------------------------|-------------------------------|---|-------------------------|
| AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER<br>155053     | A. BUILDING<br>B. WING        | <u>01</u>   | COMPLETED<br>01/11/2023 |
|                        |  |                                     | STREET                        | ADDRESS, CITY, STATE, ZIP COD   |                         |
| NAME OF                | PROVIDER OR SUPPLIE  | ĒR                                  |                               | 11TH ST   |                         |
| WATER                  | S OF RUSHVILLE   | SKILLED NURSING FACILITY, 1         | HE RUSH                       | VILLE, IN 46173   |                         |
| (X4) ID                | SUMMARY  | STATEMENT OF DEFICIENCIE            | ID                            | PROVIDER'S PLAN OF CORRECTION   | (X5)                    |
| PREFIX                 | (EACH DEFICIE  | NCY MUST BE PRECEDED BY FULL        | PREFIX                        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | E COMPLETI              |
| TAG                    | REGULATORY C   | OR LSC IDENTIFYING INFORMATION      | TAG                           | DEFICIENCY)   | DATE                    |
|                        |  |                                     |                               | 1. CORRECTIVE ACTIONS   | j                       |
|                        | Findings include:  |                                     |                               | TAKEN:  |                         |
|                        |  |                                     |                               | a. On 01/30/2023 the  |                         |
|                        |  | ions and interviews during a        |                               | Maintenance Supervisor/design   |                         |
|                        |  | with the Executive Director on      |                               | 1) repaired the door closer on t  |                         |
|                        |  | :15 p.m. and 4:00 p.m., the         |                               | corridor doors to west wing nur   | ses                     |
|                        |  | 1) West Wing Nurses Supply          |                               | supply room to ensure they  |                         |
|                        |  | th a self-closing device, failed to |                               | self-close and latch into the do  |                         |
|                        |  | h into the door frame. And (2)      |                               | frame and 2) repaired the door  |                         |
|                        | -  | urses Station "Staff Break          |                               | closer on the west wing nurses  |                         |
|                        |  | d to close and latch positively     |                               | station staff break room/medica   | al                      |
|                        | into the door fram   |                                     |                               | supply room to ensure it  |                         |
|                        |  | v at the time of the                |                               | self-closes and latches into the  |                         |
|                        | observations, the I  | Executive Director agreed the       |                               | door frame to meet set standar  | ds.                     |
|                        |  | prridor doors did not close and     |                               | The Administrator verified the v  | vork                    |
|                        | latch into the door  | frame and would not resist the      |                               | on 02/02/2023.  |                         |
|                        | passage of smoke.  |                                     |                               | b. On 01/30/2023 the  |                         |
|                        |  |                                     |                               | Maintenance Supervisor/design   | nee                     |
|                        | This finding was a   | cknowledged by the Executive        |                               | repaired the area near the  |                         |
|                        | Director at the tim  | e of discovery and again at the     |                               | doorknob in the corridor door to  | )                       |
|                        | exit conference at   | 4:45 p.m.                           |                               | the Dietary Supply on the servi   | се                      |
|                        |  |                                     |                               | hall to meet set standards. The   | э                       |
|                        | 2. Based on observ   | vation and interview, the facility  |                               | Administrator verified the work   | on                      |
|                        | failed to ensure 1   | of over 30 corridor doors would     |                               | 02/02/2023.   |                         |
|                        | resist the passage   | of smoke. This deficient            |                               | 2. ALL OTHERS WITH  |                         |
|                        | practice could affe  | ect 3 staff.                        |                               | POTENTIAL TO BE AFFECTE   | D:                      |
|                        |  |                                     |                               | a. All residents and all staff  |                         |
|                        | Findings include:  |                                     |                               | and visitors have the potential   | ío                      |
|                        |  |                                     |                               | be affected but none were. The  |                         |
|                        | Based on observat  | ions and interviews during a        |                               | Maintenance Supervisor/design   |                         |
|                        |  | with the Executive Director on      |                               | inspected all corridor doors for  |                         |
|                        |  | :15 p.m. and 4:00 p.m., the         |                               | impediments to closing and fou  | Ind                     |
|                        |  | e Dietary Supply on the service     |                               | no other negative findings.   |                         |
|                        |  | nole which penetrated               |                               | 3. MEASURES TO PREVE  | лт                      |
|                        | completely through the door near the doorknob.<br>This finding was acknowledged by the Executive |                                     | REOCCURRENCE:                 |   |                         |
|                        |  |                                     | a. On 01/30/2023 the          |   |                         |
|                        |  |                                     | Administrator in serviced the |   |                         |
|                        |  | e of discovery and again at the     |                               | Maintenance Supervisor/design   | nee                     |
|                        | exit conference at   |                                     |                               | and all staff on the requirement  |                         |
|                        |  | - <b>1</b>                          |                               | that corridor doors may not hav   |                         |
|                        | 1  |                                     |                               | I hat contact acors may not hav   | ~ I                     |

|   | NT OF DEFICIENCIES<br>OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053 | IDENTIFICATION NUMBER A. BUILDING <u>01</u>                 |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |                  |
|---|-------------------------------------|---|---|--|---|------------------|
| NAME OF PROVIDER OR SUPPLIER<br>WATERS OF RUSHVILLE SKILLED NURSING FACILITY, T |                                     | 612 E   | ADDRESS, CITY, STATE, ZIP COI<br>11TH ST<br>VILLE, IN 46173 | )  |   |                  |
| (X4) ID<br>PREFIX   | SUMMARY<br>(EACH DEFICIE            | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL    | ID<br>PREFIX  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | CTION<br>JLD BE<br>ROPRIATE   | (X5)<br>COMPLETI |
| TAG   | 3.1-19(b)                           | R LSC IDENTIFYING INFORMATION                                 | TAG   | impediments to closing a<br>self-close and latch fully<br>frame and perform month<br>inspections of the corrido<br>ensure no penetrations in<br>doors to meet set standa<br>b. Maintenance<br>Supervisor/designee will<br>all corridor doors through<br>facility monthly to ensure<br>no impediments to closin<br>they self-close and latch<br>the frame and perform in<br>of the corridor doors to e<br>penetrations in the doors<br>of the facility's Preventive<br>Maintenance Program an<br>document those inspecti<br>as appropriate. If any is<br>discovered, they will be a<br>and resolved immediatel<br>Maintenance Supervisor,<br>will review with the Admi<br>the inspection results.<br>c. The Administrator<br>monitor adherence to the<br>Preventative Maintenance<br>schedule and validate the<br>Preventative Maintenance<br>documentation is in place<br><b>4. MONITORING</b><br><b>CORRECTIVE ACTION:</b><br>a. The inspection results<br>a. The inspection result<br>supervisor/designee to the<br>Administrator will presen<br>inspection results at the<br>Quality Assurance/Perfor<br>Improvement (QA/PI) me | into the<br>hly<br>or doors to<br>in the<br>ards.<br>inspect<br>hout the<br>e there are<br>ag and<br>fully into<br>spections<br>nsure no<br>as a part<br>e<br>addressed<br>y. The<br>/designee<br>nistrator<br>will<br>e<br>e<br>e<br>e<br>e.<br>e<br>ults will<br>ntenance<br>he<br>ad the<br>t the<br>monthly<br>rmance | DATE             |

|                | R MEDICARE & MEDIO              |   |                 |  | OMB NO. 0938-039 |
|----------------|---------------------------------|---|-----------------|--|------------------|
|                | NT OF DEFICIENCIES              | X1) PROVIDER/SUPPLIER/CLIA                                  | (X2) MULTIPLE C | î.   | (3) DATE SURVEY  |
| AND PLAN       | OF CORRECTION                   | IDENTIFICATION NUMBER                                       | A. BUILDING     | <u>01</u>  | COMPLETED        |
|                |                                 | 155053  | B. WING         |  | 01/11/2023       |
| NAME OF 1      | PROVIDER OR SUPPLIE             | R   |                 | ADDRESS, CITY, STATE, ZIP COD  |                  |
|                |                                 |   | -               | 11TH ST  |                  |
| WATERS         | S OF RUSHVILLE                  | SKILLED NURSING FACILITY, T                                 | HE RUSH         | VILLE, IN 46173  |                  |
| (X4) ID        | SUMMARY                         | STATEMENT OF DEFICIENCIE                                    | ID              | PROVIDER'S PLAN OF CORRECTION  | (X5)             |
| PREFIX         | (EACH DEFICIE)                  | NCY MUST BE PRECEDED BY FULL                                | PREFIX          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE | COMPLETION       |
| TAG            | REGULATORY O                    | R LSC IDENTIFYING INFORMATION                               | TAG             | DEFICIENCY)  | DATE             |
|                |                                 |   |                 | 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.  |                  |
| (0544          |                                 |   |                 |  |                  |
| ( 0511<br>SS=E | NFPA 101<br>Utilities - Gas and | 1 Electric  |                 |  |                  |
| Bldg. 01       | Utilities - Gas and             |   |                 |  |                  |
| Blug. 01       |                                 | gas or related gas piping                                   |                 |  |                  |
|                |                                 | PA 54, National Fuel Gas                                    |                 |  |                  |
|                |                                 | viring and equipment  |                 |  |                  |
|                |                                 | PA 70, National Electric                                    |                 |  |                  |
|                | Code. Existing in               | stallations can continue in                                 |                 |  |                  |
|                | service provided                | no hazard to life.  |                 |  |                  |
|                | 18.5.1.1, 19.5.1.1              |   |                 |  |                  |
|                |                                 | on and interview, the facility                              | K 0511          | <b>K511 -</b> It is the intent of the facil                              |                  |
|                |                                 | electrical panels in the                                    |                 | to ensure all electrical panels in                                       |                  |
|                |                                 | ured from non-authorized                                    |                 | the corridors are secured from   |                  |
|                | -                               | 70, 2011 edition states 230.62                              |                 | non- authorized personnel to m   | eet              |
|                |                                 | service equipment shall be<br>ed in 230.62(A) or guarded as |                 | set standards. 1. CORRECTIVE ACTIONS                                     |                  |
|                | specified in 230.62             | =   |                 | 1. CORRECTIVE ACTIONS  |                  |
|                |                                 | rgized parts shall be enclosed                              |                 | a. On 01/11/2023 the   |                  |
|                |                                 | t be exposed to accidental                                  |                 | Maintenance Supervisor/design  | ee               |
|                |                                 | guarded as in 230.62(B).                                    |                 | locked the following electrical  |                  |
|                |                                 | gized parts that are not enclosed                           |                 | boxes: 1. West Wing Middle   |                  |
|                |                                 | n a switchboard, panelboard, or                             |                 | Corridor Lighting box 2. Box   |                  |
|                |                                 | guarded in accordance with                                  |                 | marked W-4 air conditioning and  | d                |
|                |                                 | . Where energized parts are                                 |                 | 3. 2 boxes on the East Hall to   |                  |
|                |                                 | ed in 110.27(A)(1) and (A)(2), a                            |                 | meet set standards. The  |                  |
|                | means for locking               | or sealing doors providing                                  |                 | Administrator verified the work of                                       | nn               |

| DEPARTMENT OF HEALTH AND HUMAN SERVICE | S |
|--|---|
|--|---|

|           | R MEDICARE & MEDIC   |   |                 |  | OMB NO. 0938-039 |
|-----------|----------------------|---|-----------------|--|------------------|
|           | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA                                      | (X2) MULTIPLE C |  | (X3) DATE SURVEY |
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER   | A. BUILDING     | <u>01</u>  | COMPLETED        |
|           |                      | 155053  | B. WING         |  | 01/11/2023       |
| NAME OF I | PROVIDER OR SUPPLIE  | D   | STREET          | ADDRESS, CITY, STATE, ZIP COD  | •                |
| NAME OF I | PROVIDER OR SUPPLIE  | ĸ   | 612 E           | 11TH ST  |                  |
| WATERS    | S OF RUSHVILLE S     | SKILLED NURSING FACILITY, T                                     | HE RUSH         | VILLE, IN 46173  |                  |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION       |
| TAG       | REGULATORY O         | R LSC IDENTIFYING INFORMATION                                   | TAG             | DEFICIENCY)  | DATE             |
|           | access to energized  | l parts shall be provided. This                                 |                 | 02/02/2023.  |                  |
|           | deficient practice c | ould affect staff and 30  |                 | 2. ALL OTHERS WITH   |                  |
|           | residents.           |   |                 | POTENTIAL TO BE AFFECT   | ED:              |
|           |                      |   |                 | a. All residents and all sta   | ff               |
|           | Findings include:    |   |                 | and visitors have the potential  | to               |
|           |                      |   |                 | be affected but none were. O   | n                |
|           |                      | ons and interviews during a                                     |                 | 01/27/2023 the Maintenance   |                  |
|           |                      | with the Executive Director on                                  |                 | Supervisor/designee inspecte   |                  |
|           |                      | 15 p.m. and 4:00 p.m., the                                      |                 | electrical boxes to ensure the   |                  |
|           | e e                  | l panels in were unlocked when                                  |                 | were locked and found no oth   | er               |
|           | tested:              |   |                 | negative findings.   |                  |
|           |                      | iddle corridor "Lighting" box.                                  |                 | 3. MEASURES TO PREVI   | ENT              |
|           |                      | W-4 Air Conditioning."  |                 | REOCCURRENCE:  |                  |
|           | 3. 2 of 5 Boxes of   | on the East Hall.   |                 | a. On 01/30/2023 the   |                  |
|           | This for the second  | - Lu  |                 | Administrator in serviced the  |                  |
|           | -                    | cknowledged by the Executive<br>e of discovery and again at the |                 | Maintenance Supervisor/desig   | gnee             |
|           | exit conference at 4 |   |                 | on the requirement that all electrical panels are secured to           | from             |
|           | exit conference at - | +. <del>4</del> 5 p.m.  |                 | non-authorized personnel to n  |                  |
|           | 3.1-19(b)            |   |                 | set standards.   | neel             |
|           | 5.1 19(0)            |   |                 | b. Maintenance   |                  |
|           |                      |   |                 | Supervisor/designee will inspe   | ect              |
|           |                      |   |                 | all electrical panels are secure                                       |                  |
|           |                      |   |                 | from non-authorized personne   |                  |
|           |                      |   |                 | a weekly basis as a part of the  |                  |
|           |                      |   |                 | facility's Preventive Maintenar  |                  |
|           |                      |   |                 | Program and document those   |                  |
|           |                      |   |                 | inspection results as appropria  | ate.             |
|           |                      |   |                 | If any issues are discovered, t  | hey              |
|           |                      |   |                 | will be addressed and resolve  | d                |
|           |                      |   |                 | immediately. The Maintenand  | xe 🛛             |
|           |                      |   |                 | Supervisor/designee will revie   | W                |
|           |                      |   |                 | with the Administrator the   |                  |
|           |                      |   |                 | inspection results.  |                  |
|           |                      |   |                 | c. The Administrator will  |                  |
|           |                      |   |                 | monitor adherence to the   |                  |
|           |                      |   |                 | Preventative Maintenance   |                  |
|           |                      |   |                 | schedule and validate the  |                  |
|           |                      |   |                 | Preventative Maintenance   |                  |
|           |                      |   |                 | documentation is in place.   |                  |
|           |                      |   |                 |  | I                |

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

Event ID:

IMFR21 Facility ID: 000018

If continuation sheet Page 30 of 45

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|                            | NT OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |                           |
|----------------------------|---|---|--|---|---|---------------------------|
|                            | PROVIDER OR SUPPLIE   | R<br>SKILLED NURSING FACILITY, 1  | 612 E  | i address, city, state, zip cod<br>11TH ST<br>IVILLE, IN 46173  |   |                           |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY<br>(EACH DEFICIE  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY)   | TION<br>LD BE<br>ROPRIATE   | (X5)<br>COMPLETIO<br>DATE |
| / 0740                     |   |   |  | 4. MONITORING<br>CORRECTIVE ACTION:<br>a. The inspection results<br>be presented by the Main<br>Supervisor/designee to the<br>Administrator monthly and<br>Administrator will present<br>inspection results at the m<br>Quality Assurance/Perfor<br>Improvement (QA/PI) men<br>Inspection results and syst<br>components will be review<br>the QA/PI Committee with<br>subsequent plans of correct<br>developed and implement<br>deemed necessary to ensist<br>compliance is maintained<br>This plan of correction<br>constitutes our credible<br>allegation of compliance<br>all regulatory requireme<br>Our date of compliance<br>02/02/2023. | tenance<br>e<br>d the<br>the<br>nonthly<br>mance<br>eting.<br>stem<br>ved by<br>n<br>ection<br>ted as<br>sure<br>•<br>•<br>• with<br>nts. |                           |
| K 0712<br>SS=F<br>Bldg. 01 | alarm signal and<br>conditions. Fire of<br>and unexpected<br>conditions, at lea<br>The staff is famili<br>aware that drills a<br>routine. Where of<br>9:00 PM and 6:00<br>announcement m<br>audible alarms.<br>19.7.1.4 through | nay be used instead of  | K 0712   | <b>K712</b> – It is the intent of t   | Те  | 02/03/202                 |

|                                    | NT OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053  | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING | <u>01</u>  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |
|------------------------------------|---|--|---|--|---|
|                                    | PROVIDER OR SUPPLIE   | R<br>SKILLED NURSING FACILITY, TI  | 612 E <sup>-</sup>                        | address, city, state, zip cod<br>11TH ST<br>VILLE, IN 46173  |   |
| WATERS<br>(X4) ID<br>PREFIX<br>TAG | SUMMARY<br>(EACH DEFICIENT<br>REGULATORY O<br>failed to conduct ff<br>orientation training<br>quarters. LSC 19.7<br>conducted quarter<br>facility personnel (<br>engineers, and adm<br>signals and emerge<br>varied conditions.<br>waiver states in lie<br>documented orient<br>to the current fire p<br>facility conditions,<br>instruct employees<br>temporary employees<br>to the current fire p<br>facility conditions,<br>instruct employees<br>temporary | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br><u>R LSC IDENTIFYING INFORMATION</u><br>re drills or documented<br>g on each shift for 2 of 4<br>.1.6 states drills shall be<br>y on each shift to familiarize<br>nurses, interns, maintenance<br>ninistrative staff) with the<br>ency action required under<br>QSO-20-31 1135 temporary<br>u of a physical fire drill, a<br>ation training program related<br>blan, which considers current<br>is acceptable. The training will<br>, including existing, new or<br>ees, on their current duties, life<br>and the fire protection devices<br>rea. This deficient practice<br>I patients.<br>view and interview with the<br>to n1/11/23 between 1:15 a.m.<br>following shifts were missing<br>a completed fire drill or<br>ation training:<br>second shift of 2021.<br>third shift of 2021.<br>v at the time of record review,<br>ctor agreed there were some<br>and staff has not been trained in<br>edures for the second and | HE ID<br>PREFIX<br>TAG                    | VILLE, IN 46173  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  facility to ensure to conduct quarterly fire drills or document orientation training on each shi for 4 quarters per year to meet standards.  1. CORRECTIVE ACTIONS TAKEN: a. On 01/30/2023 the Administrator in serviced the Maintenance Supervisor/design on the requirement that fire drill must be conducted at unexpect times under varying conditions least quarterly on each shift an documented to meet set standards. b. The Maintenance Supervisor/designee will condu fire drill/training for each of the three shifts and documented th results in the facilities Life Safe Binder to meet set standards b 02/03/2023. The Administrator verify the drills upon completion 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. 3. MEASURES TO PREVE REOCCURRENCE: a. Maintenance Supervisor/designee will ensur fire drills are conducted at unexpected times under varyin conditions at least quarterly on | ted<br>ft<br>set<br>set<br>set<br>s<br>nee<br>ls<br>ted<br>at<br>d<br>uct a<br>ne<br>ety<br>y<br>will<br>n.<br>D:<br>to<br>NT<br>e<br>g |
|                                    | 3.1-19(b)<br>3.1-51(c)  |  |   | each shift and documented on<br>Fire Drill Report and that<br>documentation be retained in the<br>facility's Life Safety Binder as a   | he  |

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| STATEMEN               | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA      | (X2) MULTIPLE C        | ONSTRUCTION   | (X3) DAT                | E SURVEY   |
|------------------------|---------------------|---------------------------------|------------------------|---|-------------------------|------------|
| AND PLAN OF CORRECTION |                     | IDENTIFICATION NUMBER<br>155053 | A. BUILDING<br>B. WING | 01  | COMPLETED<br>01/11/2023 |            |
|                        |                     | 100000                          |                        |   | 01/1                    | 1/2020     |
| NAME OF F              | PROVIDER OR SUPPLIE | R                               |                        | ADDRESS, CITY, STATE, ZIP COD                                   |                         |            |
|                        |                     | SKILLED NURSING FACILITY, T     |                        | 11TH ST<br>VILLE, IN 46173                                      |                         |            |
| MATERS                 |                     | SKIELED NORSING FACIENT, T      | HE KUSH                | VILLE, IN 40175   |                         |            |
| X4) ID                 | SUMMARY             | STATEMENT OF DEFICIENCIE        | ID                     | PROVIDER'S PLAN OF CORRECTI                                     | ON                      | (X5)       |
| PREFIX                 |                     | NCY MUST BE PRECEDED BY FULL    | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO | ) BE<br>PRIATE          | COMPLETION |
| TAG                    | REGULATORY O        | R LSC IDENTIFYING INFORMATION   | TAG                    | DEFICIENCY)   |                         | DATE       |
|                        |                     |                                 |                        | part of the facility's Preven                                   |                         |            |
|                        |                     |                                 |                        | Maintenance Program and   |                         |            |
|                        |                     |                                 |                        | document those inspection                                       |                         |            |
|                        |                     |                                 |                        | as appropriate. If any issu                                     |                         |            |
|                        |                     |                                 |                        | discovered, they will be ad                                     |                         |            |
|                        |                     |                                 |                        | and resolved immediately.<br>Maintenance Supervisor/d           |                         |            |
|                        |                     |                                 |                        | will review with the Admini                                     | •                       |            |
|                        |                     |                                 |                        | the inspection results.   | อแลเบเ                  |            |
|                        |                     |                                 |                        | b. The Administrator w  | ill                     |            |
|                        |                     |                                 |                        | monitor adherence to the  |                         |            |
|                        |                     |                                 |                        | Preventative Maintenance  |                         |            |
|                        |                     |                                 |                        | schedule and validate the                                       |                         |            |
|                        |                     |                                 |                        | Preventative Maintenance  |                         |            |
|                        |                     |                                 |                        | documentation is in place.                                      |                         |            |
|                        |                     |                                 |                        | 4. MONITORING   |                         |            |
|                        |                     |                                 |                        | CORRECTIVE ACTION:  |                         |            |
|                        |                     |                                 |                        | a. The inspection resul   | ts will                 |            |
|                        |                     |                                 |                        | be presented by the Mainte                                      | enance                  |            |
|                        |                     |                                 |                        | Supervisor/designee to the                                      | ;                       |            |
|                        |                     |                                 |                        | Administrator monthly and                                       |                         |            |
|                        |                     |                                 |                        | Administrator will present t                                    |                         |            |
|                        |                     |                                 |                        | inspection results at the m                                     | -                       |            |
|                        |                     |                                 |                        | Quality Assurance/Perform                                       |                         |            |
|                        |                     |                                 |                        | Improvement (QA/PI) mee   | -                       |            |
|                        |                     |                                 |                        | Inspection results and syst                                     |                         |            |
|                        |                     |                                 |                        | components will be review                                       | ed by                   |            |
|                        |                     |                                 |                        | the QA/PI Committee with  | otion                   |            |
|                        |                     |                                 |                        | subsequent plans of correct developed and implemented           |                         |            |
|                        |                     |                                 |                        | deemed necessary to ensu  |                         |            |
|                        |                     |                                 |                        | compliance is maintained.                                       |                         |            |
|                        |                     |                                 |                        | This plan of correction   |                         |            |
|                        |                     |                                 |                        | constitutes our credible  |                         |            |
|                        |                     |                                 |                        | allegation of compliance  | with                    |            |
|                        |                     |                                 |                        | all regulatory requiremen                                       |                         |            |
|                        |                     |                                 |                        | Our date of compliance is                                       |                         |            |
|                        |                     |                                 |                        | 02/03/2023.   |                         |            |
|                        |                     |                                 | 1                      | 1   |                         |            |

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|                            | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155053  |   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING |                     |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |                            |
|----------------------------|---|---|--|---------------------|--|---|----------------------------|
|                            | PROVIDER OR SUPPLIE<br>S OF RUSHVILLE   | R<br>SKILLED NURSING FACILITY, T  | HE   | 612 E               | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173  |   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | ' STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | E   | (X5)<br>COMPLETION<br>DATE |
| K 0916<br>SS=F<br>Bldg. 01 | Electrical System<br>System Alarm Ar<br>A remote annunce<br>powered is provie<br>generating room<br>observed by ope<br>annunciator is ha<br>conditions of the<br>centralized comp<br>information system<br>for the alarm ann<br>6.4.1.1.17, 6.4.1.<br>Based on observate<br>failed to ensure 1 of<br>annunciator panels<br>condition. This do<br>the residents, as we<br>facility.<br>Findings include:<br>Based on observate<br>tour of the facility<br>1/11/23 between 1<br>generator annuncial<br>light which was ill<br>reset at the panel be<br>illuminate yellow.<br>that the generator<br>unaware of any iss<br>facility is currently<br>professional.<br>This finding was a | tator that is storage battery<br>ded to operate outside of the<br>in a location readily<br>rating personnel. The<br>urd-wired to indicate alarm<br>emergency power source. A<br>outer system (e.g., building<br>em) is not to be substituted<br>unciator.<br>1.17.5 (NFPA 99)<br>ion and interview, the facility<br>of 1 emergency generator<br>s were in proper operating<br>efficient practice could affect all<br>ell as staff and visitors in the<br>ions and interviews during a<br>with the Executive Director on<br>:15 p.m. and 4:00 p.m., the<br>ator panel had a yellow service<br>uminated and when tested and<br>by the surveyor, continued to<br>The Executive Director stated<br>had recently run and she was<br>ues with the Generator, but the<br>y without a full-time maintenance | КО   | 916                 | <ul> <li>K916– It is the intent of the f to ensure the emergency generator annunciator panel in proper operating condition meet set standards.</li> <li>CORRECTIVE ACTIO TAKEN: <ul> <li>a. On 01/12/2023 the Maintenance Supervisor/des repaired the generator to enthe yellow service light is no illuminated to meet set standards. The Administrato verified repairs on 01/12/202</li> <li>ALL OTHERS WITH POTENTAL TO BE AFFECT</li> <li>a. All residents and all st and visitors have the potenti be affected but none were. facility has only one emerge generator.</li> <li>MEASURES TO PREV REOCCURRENCE:</li> <li>a. On 01/30/2023 the Administrator in serviced the Administrat</li></ul></li></ul> | s are<br>to<br>NS<br>signee<br>sure<br>t<br>or<br>23.<br>FED:<br>aff<br>al to<br>The<br>ncy<br>/ENT | 02/02/202                  |

| ·                 |                     | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |
|-------------------|---------------------|---|--|--|---|--|
| NAME OF           | PROVIDER OR SUPPLIE | ER  |  | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST   |   |  |
| WATER             | S OF RUSHVILLE      | SKILLED NURSING FACILITY, T                                   |  | VILLE, IN 46173  |   |  |
| (X4) ID<br>PREFIX | (EACH DEFICIE       | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL    | ID<br>PREFIX                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | (X5)<br>COMPLETI                            |  |
| TAG               |                     | OR LSC IDENTIFYING INFORMATION                                | TAG  | DEFICIENCY)  | DATE  |  |
|                   | 3.1-19(b)           |   |  | on the requirement the emerge  | -   |  |
|                   |                     |   |  | generator annunciator panels a   |   |  |
|                   |                     |   |  | in proper operating condition to   | )   |  |
|                   |                     |   |  | meet set standards.  |   |  |
|                   |                     |   |  | b. Maintenance   |   |  |
|                   |                     |   |  | Supervisor/designee will ensur   | e   |  |
|                   |                     |   |  | the emergency generator  |   |  |
|                   |                     |   |  | annunciator panels are in prop   |   |  |
|                   |                     |   |  | operating condition as a part o<br>facility's Preventive Maintenan                                       |   |  |
|                   |                     |   |  | Program and document those   | ue -  |  |
|                   |                     |   |  | inspection results as appropria  | to  |  |
|                   |                     |   |  | If any issues are discovered, the  |   |  |
|                   |                     |   |  | 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 w  | ill   |  |
|                   |                     |   |  | be presented by the Maintenar  | nce   |  |
|                   |                     |   |  | Supervisor/designee to the   |   |  |
|                   |                     |   |  | Administrator monthly and the  |   |  |
|                   |                     |   |  | Administrator will present the   |   |  |
|                   |                     |   |  | inspection results at the month  | ly  |  |
|                   |                     |   |  | Quality Assurance/Performanc   | e   |  |
|                   |                     |   |  | Improvement (QA/PI) meeting.   | ,   |  |
|                   |                     |   |  | Inspection results and system  |   |  |
|                   |                     |   |  | components will be reviewed b  | у   |  |
|                   |                     |   |  | the QA/PI Committee with   |   |  |
|                   |                     |   |  | subsequent plans of correction   |   |  |
|                   |                     |   |  | developed and implemented as   | s   |  |
|                   |                     |   |  | deemed necessary to ensure   |   |  |

| STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155053 |   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING   |                     | СОМРІ   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |                            |
|--|---|--|---------------------|---|---|----------------------------|
|  | PROVIDER OR SUPPLIE   | R<br>SKILLED NURSING FACILITY, T   | 612 E               | ADDRESS, CITY, STATE, ZIP<br>11TH ST<br>VILLE, IN 46173   | COD   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE                                   | (X5)<br>COMPLETION<br>DATE |
|  |   |  |                     | compliance is mainta<br>This plan of correcti<br>constitutes our cred<br>allegation of complia<br>all regulatory require<br>Our date of complian<br>02/02/2023. | on<br>lible<br>ance with<br>ements.         |                            |
| < 0918<br>SS=F<br>Bldg. 01   | Electrical System<br>System Maintena<br>The generator o<br>source and asso<br>of supplying serv<br>10-second criteri<br>monthly test, a p<br>annually confirm<br>safety and critica<br>and testing of the<br>switches are per<br>NFPA 110.<br>Generator sets a<br>exercised under<br>year in 20-40 day<br>once every 36 m<br>Scheduled test u<br>a complete simul<br>automatic or mar<br>loads, and are co<br>personnel. Maint<br>energy power so<br>accordance with<br>circuit breakers a<br>program for perio<br>components is ex-<br>manufacturer reco<br>of maintenance a<br>and readily availa | hs - Essential Electric Syste<br>hs - Essential Electric<br>ance and Testing<br>r other alternate power<br>ciated equipment is capable<br>ice within 10 seconds. If the<br>on is not met during the<br>rocess shall be provided to<br>this capability for the life<br>I branches. Maintenance<br>e generator and transfer<br>formed in accordance with<br>re inspected weekly,<br>load 30 minutes 12 times a<br>y intervals, and exercised<br>onths for 4 continuous hours.<br>Inder load conditions include<br>ated cold start and<br>hual transfer of all EES<br>onducted by competent<br>enance and testing of stored<br>urces (Type 3 EES) are in<br>NFPA 111. Main and feeder<br>are inspected annually, and a<br>odically exercising the<br>stablished according to<br>puirements. Written records<br>and testing are maintained<br>able. EES electrical panels<br>narked, readily identifiable, |                     |   |   |                            |

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|                          | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>ND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155053   |   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023                        |  |
|--------------------------|--|---|--|--|--|--|
|                          | PROVIDER OR SUPPLIEF<br>S OF RUSHVILLE S   | R<br>KILLED NURSING FACILITY, TH  | 612 E  | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OF<br>and separate from<br>Minimizing the po<br>emergency power<br>consideration for r<br>6.4.4, 6.5.4, 6.6.4   | (NFPA 99), NFPA 110,  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |
|                          | facility failed to ma<br>of monthly generate<br>12 months. Chapte<br>requires monthly te<br>the emergency elec<br>accordance with NH<br>Emergency and Sta<br>8. NFPA 110 8.4.2<br>service to be exerci<br>minimum of 30 min<br>99 requires a writte<br>performance, exerc<br>generator to be regu<br>for inspection by th<br>jurisdiction. This d<br>occupants.<br>Findings include:<br>Based on record rev<br>Executive Director<br>and 1:20 p.m., no d<br>review to show the<br>was exercised at lea<br>minimum of 30 min<br>interview at the tim<br>Executive Director<br>belief that the mont<br>done, but the faciliti<br>maintenance profes<br>showing current tes | review and interview, the<br>intain a complete written record<br>or load testing for all of the last<br>r 6.4.4.1.1.4(a) of 2012 NFPA 99<br>sting of the generator serving<br>trical system to be in<br>FPA 110, the Standard for<br>ndby Powers Systems, Chapter<br>requires diesel generator sets in<br>sed at least once monthly, for a<br>nutes. Chapter 6.4.4.2 of NFPA<br>n record of inspection,<br>ising period, and repairs for the<br>ilarly maintained and available | K 0918   | <ul> <li>K918 – It is the intent of the facility to ensure to maintain a complete written record of mont 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 generate battery backup lights are maintained to meet set standard 1. CORRECTIVE ACTIONS TAKEN: <ul> <li>a. On 01/27/2023 the</li> <li>Licensed generator</li> <li>contractor/Maintenance Supervition test and documented the results in the facilities Life</li> <li>Safety Binder to meet set standards.</li> <li>b. On 01/27/2023 the</li> </ul> </li> <li>Maintenance Supervisor/design conducted the weekly inspection of the generator and documented the results in the facilities Life Safety Binder to meet set standards.</li> <li>c. The Maintenance Supervisor/design conducted the weekly inspection of the generator and documented the results in the facilities Life Safety Binder to meet set standards.</li> <li>c. The Maintenance Supervisor/design conducted the weekly inspection of the generator and documented the results in the facilities Life Safety Binder to meet set standards.</li> <li>c. The Maintenance Supervisor/design conducted the weekly inspection of the generator and documenter the results in the facilities Life Safety Binder to meet set standards.</li> <li>c. The Maintenance Supervisor/design conducted the weekly inspection of the generator and documenter the results in the facilities Life Safety Binder to meet set standards.</li> <li>c. The Maintenance Supervisor/design conducter the annual 90 minute test and monthly 30 second test of the emergency generator battery backup lights and will documenter the results and will documenter the mergency generator battery backup lights and will documenter the mergency generator battery backup lights and will documenter the mergency generator battery backup lights and will documenter the mergency generator battery backup lights and will documenter the mergency generator battery backup lights and w</li></ul> | he<br>or<br>ds.<br>ds.<br>dsor<br>te<br>he<br>he<br>he<br>he<br>he |  |

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Event ID:

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Facility ID: 000018

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155053 |  | (X2) MULTIPLE CONSTRUC<br>A. BUILDING <u>01</u><br>B. WING   | CTION (X  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023  |                            |
|--|--|--|---|--|----------------------------|
|  | PROVIDER OR SUPPLIE  | R<br>SKILLED NURSING FACILITY, T   | 612 E 11TH S  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  |   | PROVIDER'S PLAN OF CORRECTION<br>ACH CORRECTIVE ACTION SHOULD BE<br>SS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| TAG  | This finding was a<br>Director at the time<br>exit conference at a<br>2. Based on record<br>facility failed to er<br>inspections for the<br>51 of 52 weeks. N<br>generators shall be<br>NFPA 110, Standa<br>Power Systems. N<br>Emergency Power<br>including all appur<br>inspected weekly a<br>99, 6.4.4.2 requires<br>performance, exerc<br>generator to be reg<br>for inspection by th<br>jurisdiction. This c<br>residents, staff and<br>Findings include:<br>Based on record re<br>Executive Director<br>and 1:20 p.m., the<br>to show the diesel | cknowledged by the Executive<br>e of discovery and again at the<br>4:45 p.m.<br>I review and interview, the<br>asure a written record of weekly<br>generator was maintained for<br>IFPA 99, 6.4.4.1.3 requires onsite<br>maintained in accordance with<br>ard for Emergency and Standby<br>IFPA 110, 8.4.1 requires an<br>Supply System (EPSS)<br>tenant components, shall be<br>and exercised monthly. NFPA<br>s a written record of inspection,<br>cising period, and repairs for the<br>gularly maintained and available<br>the authority having<br>leficient practice could affect all<br>tvisitors. | TAG<br>the re<br>Safet<br>stand<br>2.<br>POTI<br>a.<br>and v<br>be af<br>3.<br>REO<br>a.<br>Admi<br>Main<br>on th<br>30 m<br>minu<br>week<br>minu<br>secol<br>stand<br>b.<br>Supe<br>mont<br>for 30<br>mont<br>for 30<br>mont | DEFICIENCY)<br>esults in the facilities Life<br>ty Binder to meet set<br>dards.<br>ALL OTHERS WITH<br>ENTIAL TO BE AFFECTED<br>All residents and all staff<br>visitors have the potential to<br>ffected but none were.<br>MEASURES TO PREVEN<br>CCURRENCE:<br>On 01/30/2023 the<br>inistrator in serviced the<br>tenance Supervisor/designe<br>te requirement that a month<br>inute generator test for 30<br>tes is required, along with a<br>kly inspection, annual 90<br>tte test and monthly 30<br>nd test to meet set<br>dards.<br>The Maintenance<br>ervisor/designee will ensure<br>thly 30 minute generator test<br>0 minutes is conducted<br>thly, along with a weekly<br>ection, annual 90 minute test<br>monthly 30 second test and<br>imented in the life safety<br>er to meet set standards. | DATE<br>DATE               |
|  | year was indicated<br>"Emergency Gener<br>Checklist.". Based<br>record review, the<br>her belief that the  | was dated 12/30 however no<br>on the form entitled<br>rator - Weekly Inspection<br>on an interview at the time of<br>Executive Director stated it was<br>weekly generator tests were   | Preve<br>sche<br>Preve<br>docu  | The Administrator will<br>itor adherence to the<br>entative Maintenance<br>dule and validate the<br>entative Maintenance<br>imentation is in place.  |                            |
|  | a maintenance pro<br>showing current te  | e facility was currently without<br>fessional and no documentation<br>sting could be located.<br>cknowledged by the Executive  | a.<br>be pr   | MONITORING<br>RECTIVE ACTION:<br>The inspection results will<br>resented by the Maintenanc<br>ervisor/designee to the  |                            |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |  |
|---|--|---|--|---|---|--|
|   | PROVIDER OR SUPPLIE<br>S OF RUSHVILLE  | R<br>SKILLED NURSING FACILITY, T  | 612 E <sup>-</sup>   | address, city, state, zip co<br>11TH ST<br>/ILLE, IN 46173  | DD  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY<br>(EACH DEFICIE<br>REGULATORY O<br>Director at the tim<br>exit conference at<br>3. Based on record<br>facility failed to en<br>generator battery b<br>NFPA 110, 2010 H<br>the Level 1 or Lev<br>shall be provided w<br>emergency lightin,<br>apply to units loca<br>do not include wal<br>requires functional<br>monthly, with a m<br>maximum of 5 we<br>than 30 seconds, ()<br>conducted annuall<br>if the emergency H<br>powered and (5) W<br>inspections and tes<br>for inspection by t<br>jurisdiction. This<br>residents in the fac<br>Findings include:<br>Based on record re<br>Executive Director<br>and 1:20 p.m., no<br>review to show the<br>light at the generat<br>minimum of 90 m<br>second testing had<br>The provided doct<br>"Battery-Operated<br>Test Log" for cale<br>a 90 minute test has | A STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION<br>e of discovery and again at the<br>4:45 p.m.<br>ds review and interview, the<br>nsure 1 of 1 emergency task<br>packup lights were maintained.<br>Edition at section 7.3.1 requires<br>el 2 EPS equipment location(s)<br>with battery-powered<br>g. This requirement shall not<br>ted outdoors in enclosures that<br>k-in access. Section 7.9.3.1.1 (1)<br>I testing shall be conducted<br>inimum of 3 weeks and a<br>eks between tests, for not less<br>3) Functional testing shall be<br>y for a minimum of 1 1/2 hours<br>ighting system is battery<br>Vritten records of visual<br>sts shall be kept by the owner<br>he authority having<br>deficient practice could affect all<br>cility. | ID<br>PREFIX<br>TAG  | PROVIDERS PLAN OF CORR<br>(FACH CORRECTIVE ACTION SHA<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)<br>Administrator will prese<br>inspection results at the<br>Quality Assurance/Perfor<br>Improvement (QA/PI) m<br>Inspection results and s<br>components will be revit<br>the QA/PI Committee w<br>subsequent plans of con-<br>developed and implement<br>deemed necessary to e<br>compliance is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliant<br>all regulatory requirer<br>Our date of compliant<br>02/16/2023. | DULD BE<br>PROPRIATE     COMPLETIO<br>DATE       ind the<br>int the<br>monthly<br>pormance<br>meeting.     Image: Completion of the<br>property of the<br>pro |  |

| ENTERS FO   | RS FOR MEDICARE & MEDICAID SERVICES |  |                 |   | OMB NO. 0938-039 |
|---|-------------------------------------|--|-----------------|---|------------------|
| STATEME   | NT OF DEFICIENCIES                  | X1) PROVIDER/SUPPLIER/CLIA                                       | (X2) MULTIPLE C | CONSTRUCTION  | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053 |                                     | PLAN OF CORRECTION IDENTIFICATION NUMBER A                       |                 | 01  | COMPLETED        |
|   |                                     | B. WING  |                 | 01/11/2023  |                  |
|   |                                     |  | STREET          | ADDRESS, CITY, STATE, ZIP COD   |                  |
| NAME OF   | PROVIDER OR SUPPLIEI                | 2  | 612 E           | 11TH ST   |                  |
| WATER   | S OF RUSHVILLE S                    | SKILLED NURSING FACILITY, T                                      | HE RUSH         | VILLE, IN 46173   |                  |
| (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<br>CROSS-REFERENCED TO THE APPROPRIAT | COMPLETIO        |
| TAG   | REGULATORY OF                       | R LSC IDENTIFYING INFORMATION                                    | TAG             | DEFICIENCY)   | DATE             |
|   | This finding was ac                 | knowledged by the Executive                                      |                 |   |                  |
|   | -                                   | of discovery and again at the                                    |                 |   |                  |
|   | exit conference at 4                |  |                 |   |                  |
|   |                                     |  |                 |   |                  |
|   | 3.1-19(b)                           |  |                 |   |                  |
| 0920  | NFPA 101                            |  |                 |   |                  |
| SS=E  | Electrical Equipm                   | ent - Power Cords and  |                 |   |                  |
| Bldg. 01  | Extens                              |  |                 |   |                  |
|   | Electrical Equipm                   | ent - Power Cords and  |                 |   |                  |
|   | Extension Cords                     |  |                 |   |                  |
|   | Power strips in a                   | patient care vicinity are only                                   |                 |   |                  |
|   | used for compone                    | ents of movable  |                 |   |                  |
|   | patient-care-relate                 | ed electrical equipment  |                 |   |                  |
|   | (PCREE) assemb                      | les that have been   |                 |   |                  |
|   | assembled by qua                    | alified personnel and meet                                       |                 |   |                  |
|   | the conditions of                   | 10.2.3.6. Power strips in  |                 |   |                  |
|   | the patient care v                  | icinity may not be used for                                      |                 |   |                  |
|   | non-PCREE (e.g.                     | , personal electronics),   |                 |   |                  |
|   | except in long-ter                  | m care resident rooms that                                       |                 |   |                  |
|   | do not use PCRE                     | E. Power strips for PCREE  |                 |   |                  |
|   |                                     | r UL 60601-1. Power strips                                       |                 |   |                  |
|   |                                     | , the patient care rooms   |                 |   |                  |
|   |                                     | /) meet UL 1363. In  |                 |   |                  |
|   |                                     | ooms, power strips meet  |                 |   |                  |
|   |                                     | ds. All power strips are   |                 |   |                  |
|   |                                     | precautions. Extension   |                 |   |                  |
|   | -                                   | d as a substitute for fixed                                      |                 |   |                  |
|   |                                     | re. Extension cords used   |                 |   |                  |
|   | -                                   | moved immediately upon   |                 |   |                  |
|   |                                     | purpose for which it was   |                 |   |                  |
|   |                                     | ts the conditions of 10.2.4.                                     |                 |   |                  |
|   |                                     | 9), 10.2.4 (NFPA 99), 400-8                                      |                 |   |                  |
|   |                                     | (D) (NFPA 70), TIA 12-5  |                 |   |                  |
|   |                                     | on and interview, the facility                                   | K 0920          | <b>K920</b> – It is the intent of the                                   | 02/02/202        |
|   |                                     | f 1 power cord daisy chains                                      | K 0920          | facility to ensure power cord da  |                  |
|   |                                     | nd as a substitute for fixed                                     |                 | chains are not used as a  | азу              |
|   |                                     | 2011, 400.8 state unless   |                 |   | oot              |
|   |                                     |  |                 | substitute for fixed wiring to me                                       |                  |
|   |                                     | ted in 400.7 flexible cords and used for (1) as a substitute for |                 | set standards.<br>1.CORRECTIVE ACTIONS                                  |                  |
|   | 1 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 |  |                 |   |                  |

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/11/2023 155053 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 612 E 11TH ST WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE RUSHVILLE, IN 46173 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE fixed wiring. Article 400.8 (1) prohibits daisy TAKEN: chains, because the first extension cord (or power 1.On 01/11/2023 the strip) is now acting as a substitute for the fixed Maintenance Supervisor/designee wiring of a structure. This deficient practice could removed the power strips from the affect up to 15 residents in one smoke Medical Records office to meet compartment. set standards. The Administrator verified the removal on Findings include: 01/11/2023. 2.ALL OTHERS WITH Based on observations and interviews during a POTENTIAL TO BE AFFECTED: tour of the facility with the Executive Director on 1.All residents and all staff 1/11/23 between 1:15 p.m. and 4:00 p.m., in the and visitors have the potential to Medical Records office a power strip was plugged be affected but none were. On into another power strip and supplied power by 01/12/2023 the Maintenance another power strip and being used to supply Supervisor/designee inspected all power to equipment. Based on interview at the rooms throughout the facility for time of observation, the Executive Director agreed power strips and found no other the aforementioned power strips were daisy negative findings. chained together. **3.MEASURES TO PREVENT** REOCCURRENCE: This finding was acknowledged by the Executive 1.On 01/30/2023 the Director at the time of discovery and again at the Administrator in serviced the exit conference at 4:45 p.m. Maintenance Supervisor/designee/all staff that 3.1-19(b) 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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| . ,                      |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053   | IA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023   |                           |
|--------------------------|---|---|--|---|---|---------------------------|
|                          | PROVIDER OR SUPPLIE<br>S OF RUSHVILLE   | SKILLED NURSING FACILITY, 1   | 612 E  | t address, city, state, zip cod<br>5 11TH ST<br>HVILLE, IN 46173  |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                                  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | ION<br>D BE<br>DPRIATE  | (X5)<br>COMPLETIO<br>DATE |
| < 0927<br>SS=F           | NFPA 101<br>Gas Equipment -   | Transfilling Cylinders  |  | the inspection results.<br>3. The Administrator will<br>monitor adherence to the<br>Preventative Maintenance<br>schedule and validate the<br>Preventative Maintenance<br>documentation is in place.<br>4.MONITORING CORREC<br>ACTION:<br>1. The inspection results<br>be presented by the Maint<br>Supervisor/designee to the<br>Administrator monthly and<br>Administrator will present the<br>inspection results at the million<br>Quality Assurance/Perform<br>Improvement (QA/PI) meet<br>Inspection results and syst<br>components will be review<br>the QA/PI Committee with<br>subsequent plans of correct<br>developed and implemented<br>deemed necessary to ensit<br>compliance is maintained.<br>This plan of correction<br>constitutes our credible<br>allegation of compliance is<br>02/02/2023. | ECTIVE<br>Its will<br>enance<br>the<br>the<br>the<br>onthly<br>nance<br>ting.<br>tem<br>red by<br>ction<br>ed as<br>ure<br>with<br>tts. |                           |
| Bldg. 01                 | Gas Equipment<br>Transfilling of ox<br>another is in accor-<br>Transfilling of Hig<br>Oxygen Used for<br>any gas from one | Transfilling Cylinders<br>ygen from one cylinder to<br>ordance with CGA P-2.5,<br>gh Pressure Gaseous<br>Respiration. Transfilling of<br>e cylinder to another is<br>ent care rooms. Transfilling |  |   |   |                           |

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| CENTERS FOR | R MEDICARE & MEDIC   | AID SERVICES   |                    |  | OMB NO. 0938-039  |
|-------------|--|--|--------------------|--|---|
| STATEME     | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA   |  | (X2) MULTIPLE C    | ONSTRUCTION  | (X3) DATE SURVEY  |
| AND PLAN    | OF CORRECTION  | RECTION IDENTIFICATION NUMBER  |                    | 01   | COMPLETED   |
|             |  | 155053   | B. WING            |  | 01/11/2023  |
|             | SUMMARY  | SKILLED NURSING FACILITY, T<br>STATEMENT OF DEFICIENCIE  | 612 E <sup>-</sup> | ADDRESS, CITY, STATE, ZIP COD<br>11TH ST<br>VILLE, IN 46173<br>PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI  | (X5)<br>COMPLETION  |
| TAG         | REGULATORY OF  | R LSC IDENTIFYING INFORMATION  | TAG                | DEFICIENCY)  | DATE  |
|             | containers over 5<br>under 11.5.2.3.1 (<br>liquid oxygen con<br>containers under<br>conditions under<br>11.5.2.2 (NFPA 9<br>Based on observation   | on and interview, the facility   | K 0927             | <b>K927</b> – It is the intent of the fa   |   |
|             | failed to ensure 1 or<br>rooms was provided<br>transferring is occur<br>states, the area is po-<br>that trans-filling is<br>the immediate area<br>practice could affect<br>Findings include:<br>Based on observative<br>tour of the facility or<br>1/11/23 between 1:<br>oxygen storage/trans<br>that transferring of<br>in the room, and divindicate when transs<br>Based on interview<br>Executive Director<br>stating when trans-<br>not occurring. | f 1 oxygen storage/transfer<br>d with a sign indicating that<br>rring. NFPA 99 11.5.2.3.1(3)<br>osted with signs indicating<br>occurring and that smoking in<br>is not permitted. This deficient<br>et all residents<br>ons and interviews during a<br>with the Executive Director on<br>15 p.m. and 4:00 p.m., the<br>asfer room had a sign indicting<br>oxygen was always occurring<br>d not have the ability to<br>filling was not occurring.<br>at the time of observation, the<br>stated there was not a sign<br>filling oxygen is occurring and<br>eknowledged by the Executive<br>e of discovery and again at the | К 0927             | <ul> <li>K927- It is the intent of the factor on the factor on the ensure oxygen storage/transforming to meet set standare indicating that transferring is occurring to meet set standare incorrect a constrained of the maintenance of the maintenance Supervisor/designate installed a sign on the oxygen storage/transfer room indicates show when transfilling is occurring to meet set standards. The Administrator verified this on 01/30/2023.</li> <li>1.ALL OTHERS WITH POTENTAL TO BE AFFECT 1. All residents and all stand visitors have the potentiate be affected but none were.</li> <li>2.MEASURES TO PREVEN REOCCURRENCE: <ul> <li>a. On 02/01/2023 the DON/designee will monitor the oxygen transfilling procedure ensure all nursing staff is me set requirements per our Oxy Policy &amp; Procedures to meet standards.</li> <li>b. The DON/designee will monitor the oxygen transfilling procedure per our Oxy Policy and Procedure per our Oxygen Policy and Procedure</li> </ul> </li> </ul> | nsfer<br>gn<br>rds.<br>ignee<br>n<br>ing to<br>urring<br>t<br>r<br>ED:<br>aff<br>al to<br>NT<br>ne<br>to<br>eting<br>rgen<br>set<br>ponitor |

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|   |               | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155053                                | (X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023  |  |
|---|---------------|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br>WATERS OF RUSHVILLE SKILLED NURSING FACILITY, |               |  | 612 E  | address, city, state, zip cod<br>11TH ST<br>VILLE, IN 46173  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5)<br>COMPLETI<br>DATE   |  |
|   |               |  |  | c. The maintenance Supervise<br>ensure the Oxygen Storage R<br>signage is present as a part of<br>facility's Oxygen Storage Roo<br>Policy & Procedures and<br>document those inspection re<br>as appropriate. If any issues<br>discovered, they will be addre<br>and resolved immediately. Th<br>Maintenance Supervisor/desig<br>will review with the Administra-<br>the inspection results.<br>d. The Administrator will moni<br>adherence to the Oxygen Poli<br>Procedure and validate the<br>Preventative Maintenance<br>documentation is in place.<br><b>1.MONITORING CORRECT</b><br><b>ACTION:</b><br>1.The inspection results<br>be presented by the Maintena<br>Supervisor/designee/DON/de<br>e to the Administrator monthly<br>the Administrator will present<br>inspection results at the mont<br>Quality Assurance/Performan<br>Improvement (QA/PI) meeting<br>Inspection results and system<br>components will be reviewed<br>the QA/PI Committee with<br>subsequent plans of correction<br>developed and implemented a<br>deemed necessary to ensure<br>compliance is maintained.<br><b>This plan of correction</b><br><b>constitutes our credible</b><br><b>allegation of compliance wit</b><br><b>all regulatory requirements.</b><br><b>Our date of compliance is</b><br><b>02/02/2023.</b> | or will<br>coom<br>f the<br>m<br>sults<br>are<br>essed<br>he<br>gnee<br>ator<br>tor<br>tor<br>tor<br>tor<br>tor<br>gree<br>ator<br><b>IVE</b><br>will<br>unce<br>signe<br>and<br>the<br>hly<br>ce<br>g.<br>by<br>n<br>as |  |

|  | DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>CENTERS FOR MEDICARE & MEDICAID SERVICES |  |  |   |  |  | TED: 02/10/2023<br>RM APPROVED<br>B NO. 0938-039 |
|--|---|--|--|---|--|--|--|
| STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       C         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER       155053 |   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING                           |  | (X3) DATE SURVEY<br>COMPLETED<br>01/11/2023 |  |  |  |
|  | NAME OF PROVIDER OR SUPPLIER<br>WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE   |  |  | 612 E 1                                     | ADDRESS, CITY, STATE, ZIP COD<br>1TH ST<br>/ILLE, IN 46173   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>& LSC IDENTIFYING INFORMATION | PREFIX (EACH CORRECTIV<br>CROSS-REFERENC |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                       |

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|---------------------|------------------------------|-------|

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