STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	R-C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF HOBART SKILLED NURSING FACILITY, THE	**2901 W 37TH AVE HOBART, IN 46342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00409913, IN00411506, IN00412700, IN00413008, IN00413907, IN00415513, and IN00416438 completed on 8/30/23. Complaint IN00409913 - Corrected. Complaint IN00411506 - Corrected. Complaint IN00412700 - Corrected. Complaint IN00413008 - Corrected. Complaint IN00413907 - Corrected. Complaint IN00415513 - Corrected. Complaint IN00416438 - Corrected. Survey date: October 12, 2023 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 8 Medicaid: 25 Other: 8 Total: 41 The Waters of Hobart Skilled Nursing Facility was	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	R-C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF HOBART SKILLED NURSING FACILITY, THE	**2901 W 37TH AVE HOBART, IN 46342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00409913, IN00411506, IN00412700, IN00413008, IN00413907, IN00415513, and IN00416438. Quality review completed on 10/13/23.	{F 000}		