DEPART		FORM APPROVED					
		MEDICAID SERVICES				NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155251	B. WING			R-C 10/12/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
				2901 W 37TH AVE			
WATERS	OF HOBART SKILLED N	URSING FACILITY, THE		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	(EACH CORRECTIVE AC CROSS-REFERENCED TO	AN OF CORRECTION (X5) VE ACTION SHOULD BE ED TO THE APPROPRIATE DATE DATE		
{F 000}	INITIAL COMMENTS		{F 00	0}			
	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 IN0041300	08 - 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					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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.

PRINTED: 10/16/2023

	DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES O									
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED R-C				
		A. BUILDII	NG	F					
	155251 В.				10/12/2023				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
WATERS OF HOBART SKILLED NU	RSING FACILITY THE	2901 W 37TH AVE							
WATERO OF HOBART ORIELED NO			HOBART, IN 46342						
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE					
found to be in complian Subpart B and 410 IAC PSR to the Investigatio IN00409913, IN004115 IN00413008, IN004139 IN00416438.	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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								

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

Facility ID: 000154

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