		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2023	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526					
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/17/23 Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020 At this Emergency Preparedness survey, Waterford Crossing was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 87 and had a census of 63 at the time of this survey. Quality Review completed on 01/23/23		E 00	000	Preparation or execution of the plan of correction by Waterfor Crossing Health Center does constitute admission or agreed with the truth of the facts alleg in the statement of deficiencies. The Plan of Correction is prepand executed solely because required by the position of the Federal and State Law. The Fof Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Suron January 17, 2023. Please accept this Plan of Correction the provider's credible allegatic compliance. With this, we the provider respectfully request a desk review with paper compliato be considered in establishing that the provider is in substant compliance.	d not ment led les. Plan lee rvey as ion of lea liance ng		
Bldg. 01	Licensure Survey w	11150	K 00	000	Preparation or execution of th plan of correction by Waterfor Crossing Health Center does constitute admission or agreed with the truth of the facts alleg in the statement of deficiencie The Plan of Correction is prepand executed solely because required by the position of the	d not ment jed es. pared it is		

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

(X6) DATE

TITLE

Cassie Dunlap Executive Director 01/31/2023

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

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

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155760	B. WI	NG			2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
K 0271 SS=F Bldg. 01	AIM Number: 2008 At this Life Safety Orossing was found Requirements for Pamedicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L. Health Care Occupation of Type V (111) constructions are sprinklered. The factorial system with smoke areas open to the codetectors in the residual capacity of 87 and broof this survey. All areas where the access were sprinkle facility services were Quality Review con NFPA 101 Discharge from Explosed provides a level to provisions of 7 changes in elevation free of obstruction discharge shall be travel surface.	Code survey, Waterford not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. At was determined to be of ruction and was fully cility has a monitored fire alarm detection in the corridors, rridors and hard wired smoke dent rooms. The facility has a mad a census of 63 at the time residents have customary ered. All areas providing the sprinklered.		IAG	Federal and State Law. The Fof Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Suron January 17, 2023. Please accept this Plan of Correction the provider's credible allegatic compliance. With this, we the provider respectfully request a desk review with paper compliate be considered in establishing that the provider is in substant compliance.	e vey as on of ance	DATE
	failed to ensure 1 of	on and interview, the facility 8 exit discharge had a level ere free of obstructions, and	K 02	271	1- What corrective actions wi be accomplished for those residents found to have beer		01/30/2023

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Event ID:

2YG621 Facility ID: 011150

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760		A. BU	a. building <u>01</u>			survey eted 2023		
		ROVIDER OR SUPPLIER		•	1332 W	ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR EN, IN 46526		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Ī	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE
	IAU	constructed of hard surface in accordan Certification Letter could affect all residual emergency exit Findings include: Based on observation with the Maintenan between 1:50 p.m. a sidewalk used as an exit was uneven with sidewalk for the last on interview at the Maintenance Assist walkway for the 30 due to construction and was tore up where the surface of the sur	packed all-weather travel ce with CMS Survey and 05-38. This deficient practice dents and staff using the 300 i. ons during a tour of the facility ce Assistant on 01/17/23 and 3:00 p.m., a section of the a exit discharge for the 300 Hall th dirt and grass with no t approximately 75 feet. Based time of observation, the cant acknowledged that the 0 hall exit was dirt and grass of the portion of the building en construction crews began.		IAU	affected by the deficient practice? * There were no negative outcomes for this alleged deficient practice. The exit off of the 30 hall has a level walking surface free of obstructions. 2- How other residents have the potential to be affected by the same deficient practice to be identified and how will corrective action be taken? *All the residents of 300 hall he the potential to be affected. To were no negative outcomes. 3-What measures will be purinto place and what systemic changes will be made to ensure that the deficient practice does not reoccur? *The Director of Plant Operation and assistants were educated the Executive Director on K27. The surface has been leveled now meets the requirement of discharge from exits 7.7, 7.1.7. 18.2.7, and 19.2.7 (NFPA 101. See attached picture (K271) for the correction. The DPO will round weekly during construct to ensure that this requirement continues to be in compliance 4-How the corrective action will be monitored to ensure the deficient practice will no longer recur? *Weekly audits will be conducted to the surface of the practice will no longer recur? *Weekly audits will be conducted to the surface of the practice will no longer recur?	oooloe, by vill mad chere t c ions by 1. and f c ion t t t t t the	DATE

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

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155760	B. WI		01	01/17/2023	
		133700	D. W1			01/17/	2020
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
WATERF	ORD CROSSING				ATERFORD CIR EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=D	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting of	corridor openings in other					
	than required encl	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	-	g fire for at least 20					
		fully sprinklered smoke					
	-	only required to resist the					
	· -	e. Corridor doors and doors					
	to rooms containing	_					
		rials have positive latching					
		atches are prohibited by					
	_	hese requirements do not					
		spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
	_	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	-	device capable of keeping hen a force of 5 lbf is					
		no impediment to the					
		rs. Hold open devices that					
	_	door is pushed or pulled are					
		ed protective plates of					
		re permitted. Dutch doors					
		S are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	•					
		fire window assemblies are					
	-	sprinklered compartments				ļ	
	-	ctions in area or fire				ļ	
	resistance of glass	s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 01/17/2023	
	NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING			r address, city, state, zip cod WATERFORD CIR HEN, IN 46526	
(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 CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Show in REMARI fire protection ratio devices, etc. Based on observation failed to ensure 1 of doors on 100 Hall suitable for keeping impediment to closs the passage of smo could affect 2 resident findings include: Based on observation Assistant on 01/17. p.m., the corridor of not latch into the finiterview at the tim Maintenance Assist would not latch into need adjusting.	KS details of doors such as ings, automatics closing on and interview, the facility of 30 resident room corridor were provided with a means g the door closed, had no sing, latching and would resist ke. This deficient practice lents in room 100. on with the Maintenance /23 between 1:50 p.m. and 3:00 door to resident room 100 did rame when tested. Based on ne of observation, the stant stated the corridor door to the door frame and would viewed with the Maintenance	K 0363	1-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *There were no negative outcomes for this alleged deficient practice. The hinge to the down was replaced with new screws the latch was adjusted, which allows for the door to latch appropriately. 2-How other residents have potential to be affected by the same deficient practice will lidentified and how will corrective action be taken? *Two residents on the 100 has had the potential to be affected the alleged deficient practice. 3-What measures will be purinto place and what systemic changes will be made to ensure that the deficient practice does not reoccur? *The Director of Plant Operate and department was educated the Executive Director on K36 Corridor – Doors. The door mappropriately latches and meet the conditions of 19.3.6.3. The DPO and/or designee will rour once a month to ensure all resident doors latch appropriate see attachment K363. 4-How the corrective action will be monitored to ensure the second to ensure the conditions of the corrective action will be monitored to ensure the second will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure the conditions of the corrective action will be monitored to ensure	olili 01/30/2023 n cient or s and now the ne be the cient or s and now tthe ne be all d by t c cions d by 33 — ow ets lee nd attely. (s)

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Event ID:

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

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760 A. BUILDING 01 01/17/20			LETED		
	PROVIDER OR SUPPLIER		133	REET ADDRESS, CITY, STATE, ZIP COD 132 WATERFORD CIR OSHEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	O BE	(X5) COMPLETION DATE
				deficient practice will no longer recur? *Monthly audits will be co and reviewed by QA for a minimum of 6 months.	nducted	
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Based on observation failed to ensure 1 of as a substitute for fix 400.8 state unless sp	ent - Power Cords and ent - Power Cords and ent - Power Cords and coatient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms) meet UL 1363. In coms, power strips meet ls. 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. Eq. (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 con and interview, the facility f 1 flexible cords were not used exed wiring. NFPA-70/2011, pecifically permitted in 400.7 ables shall not be used for (1)	K 0920	1-What corrective actions be accomplished for those residents found to have laffected by the deficient practice?	se	01/30/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER				COMPL	ETED
155760		B. WING 01/17/2023				2023	
				·			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					ATERFORD CIR		
WATERFORD CROSSING				GOSHE	EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	as a substitute for fi	ixed wiring. This deficient			*There were no negative		
	practice could affec	et up to three staff.			outcomes for this alleged defic	cient	
	•	•			practice. The extension cord		
	Findings include:				removed from the office.		
					2-How other residents have	the	
	Based on observation	on during a tour of the facility			potential to be affected by th		
	with the Maintenan	ce Assistant on 01/17/23			same deficient practice will b		
		and 3:00 p.m., a mini fridge was			identified and how will		
	_	owered by an extension cord			corrective action be taken?		
		he Electrical Maintenance			*No residents had the potenti	al to	
	Office. Based on in	terview at the time of			be affected by the alleged defi		
	observation, the Ma	nintenance Assistant			practice.		
	acknowledged an ex	xtension cord was in use.			3-What measures will be put	t	
	_				into place and what systemic		
	The finding was rev	viewed with the Maintenance			changes will be made to		
	Assistant during the	e exit conference.			ensure that the deficient		
					practice does not reoccur?		
	3.1-19(b)				*The Director of Plant Operati	ions	
					was educated by the Executiv	е	
					Director on K-920 – Electrical		
					Equipment – Power Cords and	d	
					extension Cords. Extension co	ords	
					used temporarily are removed		
					immediately upon completion	of	
					the purpose for which it was		
					installed and meets the condit	ions	
					of 10.2.4, 10.2.3.6 (NFPA 99),		
					10.2.4 (NFPA99), 400-8 (NFP	A	
					70), TIA 12-5. The refrigerato	r is	
					now plugged into a wall outlet	and	
					the extension cord was remov	ed.	
					The Executive Director and/or		
					designee will round weekly to		
					ensure there is no further use	of	
					extension cords in the		
					Maintenance Office.		
					4-How the corrective action(
					will be monitored to ensure t	he	
					deficient practice will no		
					longer recur?		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2023	
NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING			STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
					*Monthly audits will be conduct and reviewed by QA for a minimum of 6 months.	cted	

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