STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING -- B. WING	01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/17/23 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 0000	Preparation or execution of this plan of correction by Waterford Crossing Health Center does not constitute admission or agreement with the truth of the facts alleged in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of the Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Survey on January 17, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance. With this, we the provider respectfully request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/17/23 Facility Number: 011150 Provider Number: 155760	K 0000	Preparation or execution of this plan of correction by Waterford Crossing Health Center does not constitute admission or agreement with the truth of the facts alleged in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassie Dunlap	Executive Director	01/31/2023

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	155760	A. BUILDING 01 B. WING	01/17/2023

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	AIM Number: 200831020 At this Life Safety Code survey, Waterford Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 87 and had a census of 63 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/23/23		Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Survey on January 17, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance. With this, we the provider respectfully request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharge had a level walking surface, were free of obstructions, and	K 0271	**1- What corrective actions will be accomplished for those residents found to have been**	01/30/2023

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	155760	A. BUILDING 01 B. WING	01/17/2023

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	constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect all residents and staff using the 300 hall emergency exit. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant on 01/17/23 between 1:50 p.m. and 3:00 p.m., a section of the sidewalk used as an exit discharge for the 300 Hall exit was uneven with dirt and grass with no sidewalk for the last approximately 75 feet. Based on interview at the time of observation, the Maintenance Assistant acknowledged that the walkway for the 300 hall exit was dirt and grass due to construction of the portion of the building and was tore up when construction crews began. Findings were discussed with the Maintenance Assistant at exit conference. . 3.1-19(b)		**affected by the deficient practice?** * There were no negative outcomes for this alleged deficient practice. The exit off of the 300 hall has a level walking surface, free of obstructions. 2- **How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** *All the residents of 300 hall had the potential to be affected. There were no negative outcomes. 3-**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** *The Director of Plant Operations and assistants were educated by the Executive Director on K271. The surface has been leveled and 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 construction to ensure that this requirement continues to be in compliance. **4-How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur?** *Weekly audits will be conducted for 4 weeks, then monthly for 2 months and reviewed by QA for a minimum of 6 months.	

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K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 30 resident room corridor doors on 100 Hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 100. Findings include: Based on observation with the Maintenance Assistant on 01/17/23 between 1:50 p.m. and 3:00 p.m., the corridor door to resident room 100 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Assistant stated the corridor door would not latch into the door frame and would need adjusting. The finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)	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 door was replaced with new screws and the latch was adjusted, which now allows for the door to latch appropriately. 2-**How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** *Two residents on the 100 hall had the potential to be affected by the alleged deficient practice. 3-**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** *The Director of Plant Operations and department was educated by the Executive Director on K363 – Corridor – Doors. The door now appropriately latches and meets the conditions of 19.3.6.3. The DPO and/or designee will round once a month to ensure all resident doors latch appropriately. See attachment K363. 4-**How the corrective action(s) will be monitored to ensure the**	01/30/2023

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			deficient practice will no longer recur? ***Monthly audits will be conducted and reviewed by QA for a minimum of 6 months.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1)	K 0920	**1-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	01/30/2023

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	as a substitute for fixed wiring. This deficient practice could affect up to three staff. Findings include: Based on observation during a tour of the facility with the Maintenance Assistant on 01/17/23 between 1:50 p.m. and 3:00 p.m., a mini fridge was plugged into and powered by an extension cord behind the desk in the Electrical Maintenance Office. Based on interview at the time of observation, the Maintenance Assistant acknowledged an extension cord was in use. The finding was reviewed with the Maintenance Assistant during the exit conference. 3.1-19(b)		*There were no negative outcomes for this alleged deficient practice. The extension cord was removed from the office. **2-How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** *No residents had the potential to be affected by the alleged deficient practice. 3-**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** *The Director of Plant Operations was educated by the Executive Director on K-920 – Electrical Equipment – Power Cords and extension Cords. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4, 10.2.3.6 (NFPA 99), 10.2.4 (NFPA99), 400-8 (NFPA 70), TIA 12-5. The refrigerator is now plugged into a wall outlet and the extension cord was removed. 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(s) will be monitored to ensure the deficient practice will no longer recur?**	

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			*Monthly audits will be conducted and reviewed by QA for a minimum of 6 months.	