STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 01 B. WING	02/27/2023

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/17/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 02/27/23 Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020 At this PSR, 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 62 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 02/28/23	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 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	NFPA 101 Discharge from Exits			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassie Dunlap	Executive Director	03/08/2023

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Bldg. 01	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 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 and Administrator on 02/27/23 between 11:20 a.m. and 11:32 a.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. Water had flooded the dirt path and was unable to travel through. Based on interview at the time of observation, the Maintenance Assistant and Administrator acknowledged that the walkway for the 300-hall exit was dirt due to construction of the portion of the building and was tore up when construction crews began and agreed that it is not an all-weather travel surface. Findings were discussed with the Maintenance Assistant, Administrator, and Regional Facilities Manager at exit conference.	K 0271	**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 exit off of the 300 hall has a level walking surface, free of obstructions. Due to the construction, the new connecting sidewalk will be installed between the dates of 4/3 and 4/8. **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 as a result of this 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 assistants were educated by the Executive Director on K271.	04/08/2023

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	This deficiency was cited on 01/17/23. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b)		The surface has been leveled and the new sidewalk is scheduled to be installed no later than April 8, 2023 which will then meet the requirement of discharge from exits 7.7, 7.1.7, 18.2.7, and 19.2.7 (NFPA 101). We respectfully ask for an extension in order to complete the scheduled work. Please see attached letter from Millstone Construction for details regarding the timeline and what is in place until the sidewalk can be installed. 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 bi-weekly for 32 months monthly for 2 months and reviewed by QA for a minimum of 6 months.	