PRINTED: 10/16/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760		IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED			
		B. WING		09/28	/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 DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE		
K 0000	REGULATORTO	R LSC IDENTIFTING INFORMATION	IAG			DATE		
IX 0000								
Bldg. 03	for a wing addition	pancy Life Safety Code Survey Memory Care Unit was Indiana Department of Health in 2 CFR 483.90(a).	K 0000	/b> /bpreparation>				
	Survey Date: 09/2	8/23						
	survey, Waterford compliance with R Medicare/Medicaid Life Safety from F National Fire Prote Life Safety Code (Care Occupancies The 2005 original Memory Care Unit determined to be o was fully sprinkler fire alarm system vin the corridors, and in resident rooms. protected by a 75-lithe new wing is progenerator both are	155760 0831020 ccupancy Life Safety Code Crossing was found not in equirements for Participation in d, 42 CFR Subpart 483.90(a), ire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 18, New Health						
		e residents have customary lered. All areas providing ere sprinklered.						

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

TITLE (X6) DATE

Judy Plantinga **Executive Director** 10/09/2023

Any defiencystatement 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 disclo 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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 03 CO		COMPL	COMPLETED	
155760		B. WING 09/28/2023			2023		
NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING			STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	Quality Review con	npleted on 10/02/23					
K 0372 SS=E Bldg. 03	SUMMARY STATEMENT OF DEFICIENCIE		K 0	372	 1. No negative outcome for this alleged deficient practic to residents or staff. 2. Licensed electrician ir on September 29, 2023. The funsealed penetrations around pipes and wires in the drop cerof Memory care were sealed around pipes and wires. 3. This is the initial survey preparation of opening of new Memory care addition. 4. This was checked by maintenance to ensure it was completed correctly this will be regularly scheduled checks for any issues. 5. 09/29/2023 completion 	ce n ive illing y for	09/29/2023

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155760		(X2) MULT A. BUILD B. WING		NSTRUCTION 03	(X3) DATE : COMPL 09/28/	ETED	
NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING		STREET ADDRESS, CITY, STATE, ZIP COD 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			O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	compartments. Findings include: Based on observation Director and the Ad 12:20 p.m., above the Care smoke wall the penetrations around interview at the time Maintenance Direct penetrations in the se The finding was rev Director and the Ad	or agreed there were unsealed					
K 0915 SS=E Bldg. 03	System Systems System Categories *Critical care roo electrical system from ajor injury or dea rooms where elect is required, are se *General care ro electrical system from injury to patiserved by a Type *Basic care room electrical system from injury to patients a patient care rooms served by an EES	oms (Category 1) in which ailure is likely to cause ath of patients, including all cric life support equipment reved by a Type 1 EES. Froms (Category 2) in which ailure is likely to cause itents (Category 2) are 1 or Type 2 EES. In second (Category 3) in which ailure is not likely to cause and rooms other than are not required to be 1. Type 3 EES life safety ernate source of power that					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>03</u>	(X3) DATE SURVEY COMPLETED 09/28/2023			
NAME OF PROVIDER OR SUPP		STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526					
PREFIX (EACH DEFICE TAG REGULATOR	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)				
3.3.138, 6.3.2 (NFPA 99), The Based on obser failed ensure the connected to 1 and 1	2.10, 6.6.2.2.2, 6.6.3.1.1 A 12-3 vation and interview, the facility e Fire Control Panel (FCP) was of 1 Life Safety branches. NFPA in 6.5.2.2.2.1 states the life safety oply power for lighting, equipment as follows: of means of egress in accordance the Life Safety Code and exit directional signs in in NFPA 101, Life Safety Code alterting systems, including the sired for systems used for the ammable medical gases as specified ations systems, where used for ons during emergency conditions. The conditions of a stream of the cation of illumination to exit ways of a streamles. The candles of the cation of the cation and select receptacles at the cation. The conditions of the cation of the cation. The cation of	K 0915	1 1. No negative outcome this alleged deficient practice 2 2. No residents or staff negative outcomes from alle deficient practice. 3 3. Licensed electrician September 29, 2023. A licen electrician moved the FCP b from X-3 equipment branch, X-4 life safety breaker box. 4 4. The maintenance dir checked to ensure FCP breawas on the life safety box X-This will be on regularly schechecks for any issues. 5 5. 09/29/2023 completion	es for 09/29/2023 e. had ged n on sed reaker to the ector aker 4. eduled			
Surety Stutien (James 11 1, commind an Dire Surety						

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 03		03	COMPLETED		
155760			B. WING			09/28/2023		
NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING				STREET ADDRESS, CITY, STATE, ZIP COD 1332 WATERFORD CIR GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE	
	items. The equipment branch (panel X-3) contained equipment items with exception of the FCP breaker which belongs on the life safety branch. Based on interview at the times of observation, the Maintenance Director agreed the FCP was connected to the equipment branch and not the Life Safety branch. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)							

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