STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	12/18/2024

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 12, 13, 16, 17 and 18, 2024 Facility number: 011150 Provider number: 155760 AIM number: 200831020 Census Bed Type: SNF/NF: 74 Residential: 85 Total: 159 Census Payor Type: Medicare: 16 Medicaid: 20 Other: 38 Total: 74 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 12/19/2024.	F 0000	Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey ending December 18, 2024. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on interview and record review, the facility failed to honor a resident's shower preference for 1 of 1 resident reviewed for choices. (Resident 13) Finding includes: During an interview, on 12/13/2024 at 9:42 A.M., Resident 13 was unsure if the facility asked her	F 0561	1 No ill effects noted from not having shower as per preference with resident # 13. 2 All residents have the potential to be affected. No issues with any other residents related to the alleged deficiency. Resident has given a preference of 3 x a	01/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	about her preference for showers. She indicated she received a shower two times a week on the evening shift. She indicated she would like to have a shower daily on the day shift, as she had never showered in the evening before this admission. A record review for Resident 13 was completed on 12/16/2024 at 1:05 P.M. Diagnoses included, but were not limited to: anemia, end stage renal disease and celiac disease. An Admission Minimum Data Set (MDS) assessment, dated 10/26/2024, indicated Resident 13 was cognitively intact and it was important to her to choose between a tub bath, shower, bed bath or sponge bath. On 12/11/2024, the census information indicated Resident 13 had moved from room 200 to room 321. A Shower Schedule, for the 200-hall, indicated room 200 received a shower on Mondays and Thursdays on day shift. A Shower Schedule for the 300-hall indicated Resident 13 received a shower on Mondays and Thursdays on the evening shift. During an interview, on 12/17/2024 at 2:46 P.M., CNA 9 indicated prior to Resident 13's admission to the facility, Resident 13 received showers on day shift in the assisted living setting. During an interview, on 12/18/2024 at 11:01 A.M., the Staff Development Director indicated residents were interviewed for their shower preference upon admission. She indicated the results of the preference interviews were		week for showers in morning per her request on non-dialysis days. 3 DHS and/or designee will complete audits on all new admissions or room moves to ensure preference is followed. 4 Audits will be discussed at QAPI monthly x 3 months or until 100% compliance is achieved.	

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	documented on the shower sheet schedule. She indicated Resident 13 had moved from the 200-hall where she received a shower on day shift and moved to the 300-hall where Resident 13 may have just been placed in a shower slot that was available. She indicated the resident's preference should have been honored. A policy was provided by the Director of Nursing, on 12/18/2024 at 11:48 A.M. The policy titled, "Resident Choice, ", indicated, " ...Resident have the right to make choices regarding their care, daily routine, religious practices, and activity participation ...." 3.1-3(u)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure a care plan for vision needs was in place for 1 of 2 residents reviewed for communication and sensory needs. (Resident 8) Finding includes: During an interview, on 12/12/2024 at 10:25 A.M., Resident 8 indicated he could not read the newspaper or the Bible. A record review for Resident 8 was completed, on 12/13/2024 at 12:57 P.M. Diagnoses included, but were not limited to: metabolic encephalopathy, major depressive disorder and macular degeneration. A Quarterly Minimum Data Set (MDS) assessment, dated 9/9/2024, indicated Resident 8 had moderate cognitive impairment and had	F 0656	1 Resident # 8 remains in the facility. Resident ‘s care plan has been updated to reflect vision issues. 2 All residents have the potential to be affected by the alleged deficiency. MDS coordinator and/or designee will complete a review on all vision impaired residents to ensure that vision impairment care plans are in place. 3 MDS and/or designee will audit for vision impairment care plans for 3 residents a week for 4 weeks then monthly for 2 months. 4 As a quality measure the DHS and/or designee will review any findings monthly x 3 with corrective action initiated if	12/31/2024

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	impaired vision and utilized corrective lenses. An Annual MDS assessment, dated 8/19/2024, indicated a CAA (care area assessment) was triggered for visual impairment for Resident 8, but a plan of care related to vision needs was not developed. A Social Service Comprehensive Note, dated 8/19/2024 at 3:36 P.M., indicated Resident 8 had impaired vision with ability to see large print but not regular print when reading newspapers or books. A care plan could not be located for impaired vision for Resident 8. During an interview, on 12/18/2024 at 11:11 A.M., the MDS (Minimum Data Set) Coordinator indicated a care plan had not been developed for vision needs for Resident 8. During an interview, on 12/18/2024 at 11:14 A.M., the Social Service Director indicated a care plan was not developed for vision needs for Resident 8 and a vision care plan should have been completed. A policy was provided by the Director of Nursing, on 12/17/2024 at 11:03 A.M. The policy titled, "Comprehensive Care Plan Guidelines", indicated, " ...To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines ...b. Care plan interventions should be reflective of the risk area(s) or disease processes that impact the individual resident ...6. Comprehensive care plans need to remain accurate and current ...."		warranted. The plan will be reviewed and updated during QAPI monthly meeting x 3 or until 100% compliance is achieved.	

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F 0658 SS=D Bldg. 00	3.1-35(a) 483.21(b)(3)(i) Services Provided Meet Professional Standards Based on observation, interview and record review, the facility failed to ensure 1 of 7 nursing staff administering medications maintained professional standards of quality. (QMA 4) Findings include: During a medication observation, on 12/16/2024 at 8:25 A.M., QMA 4 was observed to remove a soufflé medication cup from the top drawer of the 300-hall medication cart. Resident 56's name was written on the side of the souffle cup that contained 14 different medications. The top drawer of the medication cart also contained 2 more souffle cups with the names of Residents 13 and 134 written on the side of the cups. During an interview, on 12/16/2024 at 8:26 A.M., QMA 4 indicated he should not have preset the medications. On 12/18/2024 at 11:51 A.M., the Director of Nursing provided the policy titled," Medication Administration-General Guidelines", with a revision date of 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated "... 4. ... Medications are not pre-poured either in advance of the med pass or for more than one resident at a time...." 3.1-35(g)(1)	F 0658	1 No actual harm to residents who could have had the potential to be affected by the alleged practice. 2 All residents have the potential to be affected. DHS gave education on medication administration and education on medication labeling to all nurses and QMAs that day. 3 All nurses and QMA have had education on medication pass and not pre-setting mediations by DHS and/or designee. 4 DHS and/or designee will monitor med pass on random carts two times weekly for one month then one time weekly for two months. Results of audits to QAPI monthly x 3 months or until 100% compliance is achieved.	01/02/2025

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure over the counter medications were labeled appropriately for 1 of 2 medication storage carts. (300 hall- back medication cart). Finding includes: During a medication administration observation, on 12/17/2024 at 6:09 A.M., RN 11 obtained medication bottles from the cart. The following medications had labels indicating the ordering physician, resident's name or ordered dose: - a bottle of 81 mg (milligrams) aspirin. - multiple bottles of men's multi vitamin capsules - q bottle of vitamin B 12 - 5000 mg tablets - a bottle of multi-vitamins - a bottle of Acetaminophen 650 mg. During an interview, RN 11 indicated the medications observed without labels should have been labeled. On 12/17/2024 at 9:52 A.M., the Director of Nursing provided the policy titled, "Medication Ordering and Receiving from Pharmacy-Medication Labels", dated 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated "... F. Resident-specific non prescription medications (not floor stock) that are not labeled by the pharmacy are kept in the manufacture's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information listed above (see B.) is not covered. B... 1) Resident's name... 3) Medication name. 4)	F 0761	1 No ill effects noted to residents that had over the counter medications in cart not labeled. 2 All residents with over-counter medications have the potential to be affected. All Medication carts were audited to ensure proper labeling. 3 Education was presented by DHS and/or designee to all nurses and QMA's to ensure how to properly label an over-the-counter medication. 4 Audits will be completed one time weekly for one month then every other week for 2 months. Results of audits will be brought to QAPI monthly x 3 months or until 100% compliance is achieved.	01/02/2025

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	Strength of medication. 5) Prescriber's name... 8) "Beyond use" (or expiration) date of medication...." 3.1-25(j)(l)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to follow infection control practices regarding enhanced barrier precautions for 1 of 1 resident reviewed for dialysis care. (Resident 13) Finding includes: A record review for Resident 13 was completed on 12/16/24 at 1:05 P.M. Diagnoses included, but were not limited to: anemia, end stage renal disease and dependence on renal dialysis. An Admission Minimum Data Set (MDS) assessment, dated 10/26/2024, indicated Resident 13 had moderate cognitive impairment and received dialysis care. A Physician's Order, dated 11/2/2024, indicated staff were to use enhanced barrier precautions, wearing a gown and gloves at minimum, during high-contact care activities three times a day. A current Care Plan, initiated on 10/22/2024, indicated Resident 13 required enhanced barrier precautions (EBP) during high-contact care related to presence of dialysis treatment with a fistula. Interventions included, but were not limited to: don/doff and dispose of PPE (Patient Protective Equipment) systematically and appropriately per policy, face mask to be utilized	F 0880	1 No actual harm to resident #13 by the alleged deficient practice. Resident remains at facility. 2 All residents could have the potential to be affected. Education given to staff members that day on EBP signage/PPE use. 3 Education was given to all nursing staff on PPE and EBP signage. EBP to be worn while giving care and will be monitored with new admissions and any other residents requiring PPE and EBP. The DHS and/or designee will monitor the wearing of PPE and signage. 4 DHS and/or designee will audit 2 times weekly on random halls for one month then once a week every other week for 2 months with audit results brought to QAPI monthly x 3 months or until 100% compliance obtained.	01/02/2025

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	as needed and utilize gown and gloves per EBP policy during high contact ADL (Activities of Daily Living) care (e.g. dressing, showering/bathing, hygiene, transfers, toileting/changing briefs) and during linen changes. During an observation, on 12/16/2024 at 1:29 P.M., no precautionary signage or personal protective equipment (PPE) was observed outside Resident 13's room. During an observation and interview, on 12/17/2024 at 11:04 A.M., Resident 13 indicated the staff did not wear PPE, including gowns, gloves and mask when they provided direct care. There was no signage outside the room that indicated enhanced barrier precautions were in place and no PPE equipment was inside or outside of the room. During an observation, on 12/18/2024 at 9:52 A.M., CNA 8 was providing care for Resident 13 in the bathroom. CNA 8 was dressing Resident 13 as the resident sat on the toilet. The CNA did not have on any PPE. CNA 8 indicated he did not think PPE was required for direct care with Resident 13. He indicated he had utilized only gloves when he provided personal care to Resident 13. During an interview, on 12/18/2024 at 9:54 A.M., RN 7 indicated Resident 13 was the only resident in her care that required enhanced barrier precautions. She indicated enhanced barrier precautions were only utilized when providing care for Resident 13's dialysis fistula. A policy was provided by the Director of Nursing, on 12/18/2024 at 11:48 A.M. The policy titled,			

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	"Enhanced Barrier Precautions [EBP] Standard Operating Procedure", indicated, " ...1. Enhanced Barrier Precautions [EPB] will be in place during high-contact care activities for residents with the following conditions:..ii. All Residents with indwelling medical devices ...3. High-contact care activities include but are not limited to: morning and evening ADL [activities of daily living] care, toileting, and showers ...." 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 12, 13, 16, 17 and 18, 2024 Facility number: 011150 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey ending December 18, 2024. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure outdated foods were removed and	R 0273	1 1. No residents were affected by the alleged deficiency. The	01/02/2025

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	utensils were clean before storing in 1 of 1 kitchen. This had the potential to affect 85 of 85 residents who consumed food from the kitchen. Findings include: 1. During the initial kitchen tour on 12/12/2024 at 10:40 A.M. with the Assistant Director of Food Services, the following was observed: a. One bag of hamburger buns with a use by date of 12/11/2024. b. One loaf of rye bread with a use by date of 12/3/2024. 2. During a follow-up observation on 12/13/2024 at 9:02 A.M. with the Director of Food Services, the following was observed in the clean utensils drawer. a. There were two ice cream scoops, put away as clean, with dry food debris left on them. b. There was a whisk, put away as clean, with dried food and grease left on it. During an interview on 12/12/2024 at 12:46 A.M., the Assistant Director of Food Services indicated the bag of hamburger buns and loaf of rye bread should have been thrown away. During an interview on 12/13/2024 at 9:05 A.M., the Director of Food Services indicated the 2 ice cream scoops and whisk should have been cleaned prior to placing them in the drawer. On 12/13/2024 at 2:00 P.M., the Executive Director provided the policy titled "Food Production Guidelines- Sanitation and Safety," no date and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To provide clear direction and understanding of safe and sanitary handling of food during production.		ADFS disposes of the Bread and checks all drawers for any soiled utensils routinely. 2 2. All residents have the potential to be affected by the alleged deficiency. No complaints or issues related to expired items or soiled utensils. Education completed with culinary staff on checks of expiration dates and checking drawers for soiled utensils. 3 3. DFS or designee will complete an audit and ensure all dates are not expired and utensils in drawers are not soiled. Audits 3x per week x 4 weeks then once weekly for 4 weeks, or until 100% compliance is achieved. 4 4. As a quality measure the DFS and/or designee will review the findings, and corrective action will be implemented and brought to QAPI monthly x 3 or until 100% compliance is achieved.	

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	24. Dishes and silverware are free from chips, cracks, or stains and have a glaze intact...."			