CORRECTION  VIDER OR SUPPLIEF	IDENTIFICATION NUMBER 155760	A. BU B. WI		00	COMPL	ETED
VIDER OR SUPPLIER	155760	B. WI				
VIDER OR SUPPLIER			NG		12/18/	2024
RD CROSSING	t		1332 W	ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR EN, IN 46526	•	
SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC .	COMPLETION
REGULATORY OF			IIE	DATE		
desidential Licensures dates: December 19 dates: December 19 dates: 01 drovider number: 1	This visit included a State are Survey.  The survey.  This visit included a State are Survey.  The survey are survey.  This visit included a State are survey.	F 00	000	plan of correction by The Residence at Waterford Cross does not constitute admission agreement of truth to the facts alleged or conclusions set fort the statement of deficiencies. plan of correction is submitted order to respond to the allegar of noncompliance cited during annual survey ending Decemb	sing or s h on The l in tion the	
Cesidential: 85 Cotal: 159 Census Payor Type Medicare: 16 Medicaid: 20 Other: 38 Cotal: 74				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.		
ccordance with 41 Quality Review cor	0 IAC 16.2-3.1. inpleted on 12/19/2024.					
elf-Determination	n					
ailed to honor a resort of 1 resident reviews inding includes:  Ouring an interview	sident's shower preference for ewed for choices. (Resident 13)	F 05	561	having shower as per preferer with resident # 13.  2 All residents have the potential to be affected. No iss with any other residents relate the alleged deficiency. Reside	nce sues ed to ent	01/02/2025
This is said to the control of the said of the control of the cont	summary (EACH DEFICIEN REGULATORY OF  this visit was for a deensure Survey. esidential Licensurvey dates: Decensure Survey dates: Decensurity number: 1 IM number: 2008 ensus Bed Type: NF/NF: 74 esidential: 85 otal: 159 ensus Payor Type (edicare: 16 fedicaid: 20 ther: 38 otal: 74 these deficiencies in the coordance with 41 uality Review core 33.10(f)(1)-(3)(8) elf-Determination ased on interview iled to honor a resident review inding includes: uring an interview	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for a Recertification and State (censure Survey. This visit included a State esidential Licensure Survey.  The provider survey dates: December 12, 13, 16, 17 and 18, 2024  The provider number: 011150 The provider number: 155760  The provider number: 200831020  The provider number:	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for a Recertification and State decensure Survey. This visit included a State desidential Licensure Survey.  The state of the state	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  This visit was for a Recertification and State icensure Survey. This visit included a State esidential Licensure Survey.  The provider number: 011150 rovider number: 155760 rovider number: 155760 rovider number: 200831020 rensus Bed Type:  NF/NF: 74 rovider number: 1559 rotal: 159 rotal: 16 rotal: 16 rotal: 16 rotal: 16 rotal: 174 rotal: 174 rotal: 174 rotal: 175 rota	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for a Recertification and State electronic survey. This visit included a State electronic survey. This visit included a State electronic survey and test in the facts alleged or conclusions set for the statement of deficiencies. plan of correction is submitted order to respond to the allegat of noncompliance cited during annual survey ending December 12, 13, 16, 17 and 18, 2024  The statement of deficiencies plan of correction is submitted order to respond to the allegat of noncompliance cited during annual survey ending December 18, 2024. Please accept this of correction as the provider's credible statement of compliance with this, we the provider required a desk review with paper compliance to be considered establishing that the provider is substantial compliance.  F 0561  1 No ill effects noted from having shower as per preference for of 1 resident reviewed for choices. (Resident 13)  2 All residents have the potential to be affected. No iss with any other residents relates the alleged deficiency. Residents and the provider required as the provider and record review, on 12/13/2024 at 9:42 A.M.	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  BY PREFIX TAG  PREFIX TAG PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG PREFIX

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

TITLE

(X6) DATE

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 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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	1 1	UILDING	onstruction 00	(X3) DATE ( COMPL 12/18/	ETED
	PROVIDER OR SUPPLIEF	<b>.</b>		1332 W	ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE
	about her preference she received a show evening shift. She is have a shower daily never showered in the admission.  A record review for 12/16/2024 at 1:05 were not limited to disease and celiace of the same and celiace of	e for showers. She indicated wer two times a week on the indicated she would like to you on the day shift, as she had the evening before this.  The Resident 13 was completed on P.M. Diagnoses included, but anemia, end stage renal disease.  Immum Data Set (MDS)  10/26/2024, indicated Resident intact and it was important to been a tub bath, shower, bed in the census information indicated even from room 200 to room  12. For the 200-hall, indicated a shower on Mondays and hift.  13. For the 300-hall indicated and a shower on Mondays and wening shift.  14. For the 300-hall indicated and a shower on Mondays and wening shift.  15. For the 300-hall indicated and a shower on Mondays and wening shift.  16. For the 300-hall indicated and a shower on Mondays and wening shift.  17. For the Resident 13's admission dent 13 received showers on			week for showers in morning pher request on non-dialysis da 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 QAPI monthly x 3 months or u 100% compliance is achieved.	ys. at ntil	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/18/2024
	ROVIDER OR SUPPLIER		1332 V	ADDRESS, CITY, STATE, ZIP COD WATERFORD CIR IEN, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0656 SS=D Bldg. 00	indicated Resident I where she received moved to the 300-hi just been placed in a available. She indic should have been he A policy was provide on 12/18/2024 at 11 "Resident Choice," the right to make che daily routine, religion participation"  3.1-3(u)(1)  483.21(b)(1)(3)  Develop/Implement Based on interview failed to ensure a carplace for 1 of 2 resident communication and Finding includes:  During an interview Resident 8 indicated newspaper or the Bina A record review for 12/13/2024 at 12:57 were not limited to: major depressive didegeneration.  A Quarterly Minimulassessment, dated 9.	ded by the Director of Nursing, :48 A.M. The policy titled, indicated, "Resident have oices regarding their care, ous practices, and activity  and record review, the facility re plan for vision needs was in dents reviewed for sensory needs. (Resident 8)  and record review, the facility re plan for vision needs was in dents reviewed for sensory needs. (Resident 8)  by, on 12/12/2024 at 10:25 A.M., he could not read the ble.  Resident 8 was completed, on P.M. Diagnoses included, but metabolic encephalopathy, sorder and macular	F 0656	1 Resident # 8 remains in the facility. Resident 's care plan he been updated to reflect vision issues. 2 All residents have the potential to be affected by the alleged deficiency. MDS coordinator and/or designee who complete a review on all vision impaired residents to ensure the vision impairment care plans a place. 3 MDS and/or designee will audit for vision impairment care plans for 3 residents a week for weeks then monthly for 2 months 4. As a quality measure the DHS and/or designee will revie any findings monthly x 3 with corrective action initiated if	ill nat re in e r 4 ths.

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES  OF CORRECTION				(X3) DATE COMPI 12/18	LETED	
	PROVIDER OR SUPPLIE	R		1332 W	ADDRESS, CITY, STATE, ZIP COD /ATERFORD CIR EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION d utilized corrective lenses.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Warranted. The plan will be	ATE	(X5) COMPLETION DATE
	An Annual MDS a indicated a CAA (or triggered for visual	ssessment, dated 8/19/2024, care area assessment) was impairment for Resident 8, but ed to vision needs was not			reviewed and updated during monthly meeting x 3 or until 1 compliance is achieved.		
	8/19/2024 at 3:36 I impaired vision wi	Comprehensive Note, dated P.M., indicated Resident 8 had th ability to see large print but hen reading newspapers or					
	A care plan could revision for Resident	not be located for impaired 8.					
	the MDS (Minimus	w, on 12/18/2024 at 11:11 A.M., m Data Set) Coordinator an had not been developed for esident 8.					
	the Social Service was not developed	w, on 12/18/2024 at 11:14 A.M., Director indicated a care plan for vision needs for Resident 8 lan should have been					
	on 12/17/2024 at 1 "Comprehensive C "To ensure apprecommunication that severity/stability of disability, or disease federal guidelines should be reflective processes that impage	ded by the Director of Nursing, 1:03 A.M. The policy titled, are Plan Guidelines", indicated, opriateness of services and at will meet the resident's needs, of conditions, impairment, se in accordance with state andb. Care plan interventions of the risk area(s) or disease act the individual resident6. are plans need to remain					

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accurate and current ...."

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PRINTED: 01/06/2025 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			C	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTII A. BUILDII B. WING	LE CONSTRUCTION NG <u>00</u>	COM	e survey pleted 8/2024
	PROVIDER OR SUPPLIER		13	REET ADDRESS, CITY, STA 32 WATERFORD CIF DSHEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	IX (EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 0658 SS=D Bldg. 00	Standards Based on observation review, the facility staff administering a professional standard.  Findings include:  During a medication 8:25 A.M., QMA 4 soufflé medication written on the side contained 14 differed.  The top drawer of the contained 2 more see Residents 13 and 13 cups.  During an interview QMA 4 indicated he medications.  On 12/18/2024 at 1 Nursing provided the Administration-Ger revision date of 11/2 was the one current policy indicated "	the medication cart also buffle cups with the names of 34 written on the side of the 4, on 12/16/2024 at 8:26 A.M., e should not have preset the 1:51 A.M., the Director of the policy titled," Medication the policy titled, with a 2018, and indicated the policy ly used by the facility. The 4 Medications are not advance of the med pass or	F 0658	who could have to be affected be practice.  2 All resider potential to be education on medication labe and QMAs that 3 All nurses had education and not pre-set DHS and/or de 4 DHS and/ monitor med pacarts two times month then one two months. Re QAPI monthly	nts have the affected. DHS gave nedication and education on eling to all nurses t day. and QMA have on medication pass tting mediations by esignee.	01/02/2025

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3.1-35(g)(1)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		155760	B. WI	NG			12/18/2024	
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R			VATERFORD CIR			
WATERF	FORD CROSSING				EN, IN 46526			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0761	483.45(g)(h)(1)(2)	)						
SS=D	Label/Store Drugs							
Bldg. 00		G						
	Based on observati	on, interview and record	F 07	761	1 No ill effects noted to		01/02/2025	
	review, the facility	failed to ensure over the			residents that had over the co	unter		
	counter medication	s were labeled appropriately			medications in cart not labeled	d.		
	for 1 of 2 medication	on storage carts. (300 hall- back			2 All residents with			
	medication cart).				over-counter medications hav	e the		
	Finding includes:				potential to be affected. All Medication carts were audited ensure proper labeling.	I to		
	_	on administration observation,			3 Education was presented	•		
		:09 A.M., RN 11 obtained			DHS and/or designee to all nu	ırses		
		from the cart. The following			and QMA's to ensure how to			
		bels indicating the ordering			properly label an over-the-cou	ınter		
		's name or ordered dose:			medication.			
		(milligrams) aspirin.			4 Audits will be completed			
	_	f men's multi vitamin capsules			time weekly for one month the			
	_	n B 12 - 5000 mg tablets			every other week for 2 months			
	- a bottle of multi-v				Results of audits will be broug			
	- a bottle of Acetan	ninopnen 650 mg.			QAPI monthly x 3 months or the solution of the			
	During an interview	w, RN 11 indicated the			10070 compliance is deflicated	•		
	_	ved without labels should have						
	been labeled.							
	On 12/17/2024 at 9	9:52 A.M., the Director of						
		he policy titled, "Medication						
		iving from Pharmacy-						
	~	", dated 11/2018, and indicated						
		one currently used by the						
	facility. The policy							
		on prescription medications						
	(not floor stock) the	at are not labeled by the						
	pharmacy are kept	in the manufacture's original						
	container and ident	ified 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 a	above (see B.) is not covered.						
	B 1) Resident's na	ame 3) Medication name. 4)						

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IENCIES TION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/18/2024
		1332 \	WATERFORD CIR	
H DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
of medicat use" (or ex on"	ion. 5) Prescriber's name 8)			
rectices reports of the facility ractices reports for 1 of the face (Residual Residual Residu	ty failed to follow infection garding enhanced barrier 1 resident reviewed for dent 13)  President 13 was completed on M. Diagnoses included, but anemia, end stage renal ence on renal dialysis.  Immum Data Set (MDS) 0/26/2024, indicated Resident gnitive impairment and re.  President 13 was completed on M. Diagnoses included Resident gnitive impairment and re.  Proposition of the president gnitive impairment and rectivities three times a day.  Proposition of the president gnitive impairment and rectivities three times a day.  Proposition of the president gnitive impairment and gnitive impairment and rectivities three times a day.  Proposition of the president gnitive impairment and	F 0880	1 No actual harm to reside #13 by the alleged deficient practice. Resident remains at facility. 2 All residents could have potential to be affected. Educingiven to staff members that discept signage/PPE use. 3 Education was given to a nursing staff on PPE and EBF signage. EBP to be worn whill giving care and will be monitod with new admissions and any other residents requiring PPE EBP. The DHS and/or design will monitor the wearing of PP and signage. 4 DHS and/or designee with audit 2 times weekly on random halls for one month then once week every other week for 2 months with audit results broat to QAPI monthly x 3 months of until 100% compliance obtain	the ation ay on all o e ared and ee PE
	or SUPPLIEF OSSING SUMMARY H DEFICIEN LATORY OF of medicat use" (or ex on"  (I) a)(1)(2)(4) n Prevention oractices rep ons for 1 of care. (Resid includes: review for at 1:05 P.I. limited to: and dependent ission Minimited to: and dependent care to use en a gown and tact care ac at Care Plant I Resident ons (EBP) of presence intervention of don/doff re Equipme	IDENTIFICATION NUMBER 155760  OR SUPPLIER  OSSING  SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION of medication. 5) Prescriber's name 8) use" (or expiration) date of on"  (1)  a)(1)(2)(4)(e)(f) n Prevention & Control n observation, record review and w, the facility failed to follow infection oractices regarding enhanced barrier ons for 1 of 1 resident reviewed for care. (Resident 13)	TION   IDENTIFICATION NUMBER   155760   B. WING   STREET   1332 M GOSF   GOSF	TION 155760  DESING  SUPPLIER  OSSING  SUPPLIER  OSSING  SUPPLIER  OSSING  SUPPLIER  OSSING  SUPPLIER  OSSING  SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION of medication. 5) Prescriber's name 8) use" (or expiration) date of on"  (I)  a)(1)(2)(4)(e)(f) 1 Prevention & Control 1 observation, record review and w, the facility failed to follow infection reactices regarding enhanced barrier mas for 1 of 1 resident reviewed for care. (Resident 13)  are for 1 of 1 resident reviewed for care. (Resident 13 was completed on at 1:05 P.M. Diagnoses included, but limited to: anemia, end stage renal and dependence on renal dialysis. sission Minimum Data Set (MDS) ent, dated 10/26/2024, indicated Resident dialysis care.  1 Care Plan, initiated on 10/22/2024, at Resident 13 required enhanced barrier most (EBP) during high-contact care op presence of dialysis treatment with a atterventions included, but were not oc don/doff and dispose of PPE (Patient e Equipment) systematically and

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/18/2024
	PROVIDER OR SUPPLIEF		1332 W	ADDRESS, CITY, STATE, ZIP COD VATERFORD CIR EN, IN 46526	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRIES OF TH	PRIATE COMPLETION
TAG	as needed and utilize policy during high of Daily Living) care (showering/bathing, toileting/changing bechanges.  During an observation opercautionary sign equipment (PPE) with 13's room.  During an observationary and the staff did not we gloves and mask with There was no signal indicated enhanced place and no PPE end of the room.  During an observationary and observationary and observationary and the place and no PPE end of the room.  During an observationary and observationary and observationary and the place and no PPE end of the room.  During an observationary and observat	hygiene, transfers, priefs) and during linen  ion, on 12/16/2024 at 1:29 P.M., gnage or personal protective as observed outside Resident  ion and interview, on 4 A.M., Resident 13 indicated ar PPE, including gowns, nen they provided direct care. ge outside the room that barrier precautions were in quipment was inside or outside  ion, on 12/18/2024 at 9:52 providing care for Resident 13 p. NA 8 was dressing Resident 13 p. NA 8 was dressing Resident 13 p. NA 8 indicated he did not ired for direct care with dicated he had utilized only vided personal care to  ion, on 12/18/2024 at 9:54 A.M., ident 13 was the only resident tired enhanced barrier dicated enhanced barrier ally utilized when providing	TAG	DEFICIENCY	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155760	B. W	NG		12/18/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERE	ODD CDOSSING				EN, IN 46526		
WATERF	ORD CROSSING			GOSHE	EN, IN 40320		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	"Enhanced Barrier I	Precautions [EBP] Standard					
	Operating Procedure	e", indicated, "1. Enhanced					
	Barrier Precautions	[EPB] will be in place during					
	high-contact care ac	tivities for residents with the					
	following condition	s:ii. All Residents with					
	indwelling medical	devices3. High-contact care					
	activities include bu	t are not limited to: morning					
		activities of daily living] care,					
	toileting, and showe	ers"					
	3.1-18(a)						
R 0000							
Bldg. 00							
		State Residential Licensure	R 0	000	Preparation and execution of t	his	
	-	acluded a Recertification and			plan of correction by The		
	State Licensure Sur	vey.			Residence at Waterford Cross	ing	
					does not constitute admission	or	
	•	mber 12, 13, 16, 17 and 18,			agreement of truth to the facts		
	2024				alleged or conclusions set fort		
					the statement of deficiencies.		
	Facility number: 01	1150			plan of correction is submitted		
					order to respond to the allegat		
	Residential Census:	85			of noncompliance cited during		
					annual survey ending Decemb		
		ntial Findings are cited in			18, 2024. Please accept this	olan	
	accordance with 410	0 IAC 16.2-5.			of correction as the provider's		
					credible statement of compliar		
					With this, we the provider requ	iest	
					a desk review with paper		
					compliance to be considered in		
					establishing that the provider i	s in	
					substantial compliance.		
D 0075							
R 0273	410 IAC 16.2-5-5.						
DI L CC	Food and Nutrition	nal Services - Deficiency					
Bldg. 00	B 1 1 1	1					
		on and interview, the facility	R 0	273	1 1. No residents were affe		01/02/2025
	tailed to ensure outo	dated foods were removed and			by the alleged deficiency. The		

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

PRINTED: 01/06/2025 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER  WATERFORD CROSSING  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  REFEIX  (RACH DEPICIENCY MICST BE PRECEDED BY FULL  REGILATIONS (18.5 EDIENTLY) MINORMATION  ATA  REGILATIONS (18.5 EDIENTLY) MINORMATION  Lutensils were clean before storing in 1 of 1  kichen. 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 12/12/2024.  2. During a follow-up observation on 12/13/2024 at 9.00 A.M. with the Director of Food Services, the following was observed in the clean utensils drawer.  a. There were two ice cream secops, 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 cleaned prior to placing them in the drawer.  On 12/13/2024 at 2:00 P.M., the Executive Director provided the policy utiled "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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/18/2024	
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION  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:  I. 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 12/3/2024.  2. During a follow-up observation on 12/13/2024 at 9.05 A.M., 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 12/13/2024 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 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				1332 V	VATERFORD CIR	•
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 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 bag of hamburger buns and loaf of rye bread 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	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
and sanitary handling of food during production.		utensils were clean kitchen. This had the residents who constant of the residents who constant indicated it was the bythe facility. The provide clear direct in the same of 12/13/2024 at 25 provided the policy. Guidelines- Sanitati indicated it was the bythe facility. The provide clear direct is said to constant in the clean is the constant in the constant in the constant in the clean in the clean in the constant in the clean in the	before storing in 1 of 1 e potential to affect 85 of 85 amed food from the kitchen.  kitchen tour on 12/12/2024 at e Assistant Director of Food ing was observed: arger buns with a use by date read with a use by date of  up observation on 12/13/2024 at Director of Food Services, the rved in the clean utensils  ce cream scoops, put away as d debris left on them. k, put away as clean, with se left on it.  or on 12/12/2024 at 12:46 A.M., or of Food Services indicated er buns and loaf of rye bread rown away.  or on 12/13/2024 at 9:05 A.M., d Services indicated the 2 ice whisk should have been cing them in the drawer.  100 P.M., the Executive Director titled "Food Production on and Safety," no date and policy currently being used policy indicated, "Purpose: To ion and understanding of safe		ADFS disposes of the Bread a checks all drawers for any so utensils routinely.  2 2. All residents have the potential to be affected by the alleged deficiency. No compla or issues related to expired its or soiled utensils. Education completed with culinary staff of checks of expiration dates and checking drawers for soiled utensils.  3 3. DFS or designee will complete an audit and ensured dates are not expired and ute in drawers are not soiled. Aud 3x per week x 4 weeks then of weekly for 4 weeks, or until 10 compliance is achieved.  4 4. As a quality measure to DFS and/or designee will revite findings, and corrective active and will be implemented and brout to QAPI monthly x 3 or until 10.	and diled saints ems on d sits once 00% he ew ction ght

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/18/2024	
	PROVIDER OR SUPPLIER			1332 W	ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		erware are free from chips, I have a glaze intact"					

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