STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155576	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF HARTFORD CITY SKILLED NURSING FACILITY	**0548 S 100 W HARTFORD CITY, IN 47348**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00451692 and IN00451250. Complaint IN00451692 - No deficiencies related to the allegations are cited. Complaint IN00451250 - No deficiencies related to the allegations are cited. Survey dates: January 27, 28, 29, 30, and 31, 2025 Facility number: 000289 Provider number: 155576 AIM number: 100289460 Census Bed Type: SNF/NF: 39 SNF: 1 Total: 40 Census Payor Type: Medicare: 7 Medicaid: 31 Private: 2 Total: 40 Waters of Hartford City Skilled Nursing Facility was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey and the Investigation of Complaints IN00451692 and IN00451250. Quality review completed February 5, 2025.	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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