STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING _____ B. WING _____	R-C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	**2640 COLD SPRING RD INDIANAPOLIS, IN 46222**

(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 Post Survey Revisit (PSR) to the Investigation of Complaints IN00345145, IN00345543, IN00349638, IN00350319, and IN00351165 completed on April 23, 2021. This visit was in conjunction with the PSR for the Investigation of Complaints IN00353892, IN00353253, IN00353332, and IN00353045 completed on June 12, 2021. This visit included a PSR to the COVID-19 Focused Infection Control Survey completed on June 12, 2021. Complaint IN00345145 - Corrected. Complaint IN00345543 - Corrected. Complaint IN00349638 - Corrected. Complaint IN00350319 - Corrected. Complaint IN00351165 - Corrected. Complaint IN00353892 - Corrected. Complaint IN00353253 - Corrected. Complaint IN00353332 - Corrected. Complaint IN00353045 - Corrected. Survey dates: July 20, 21, 22, and 23, 2021 Facility number: 00376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 5 Medicaid: 38 Other: 12 Total: 55	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING _____ B. WING _____	R-C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	**2640 COLD SPRING RD INDIANAPOLIS, IN 46222**

(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}	Continued From page 1 Alpha Home - A Waters Community was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00345145, IN00345543, IN00349638, IN00350319, and IN00351165. Quality review completed on July 29, 2021.	{F 000}		