STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155150	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	**640 W ELLSWORTH ST COLUMBIA CITY, IN 46725**

(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 the Investigation of Complaints IN00437996, IN00438039, IN00438052, and IN00438721. Complaint IN00437996 - No deficiencies related to the allegations are cited. Complaint IN00438039 - No deficiencies related to the allegations are cited. Complaint IN00438052 - No deficiencies related to the allegations are cited. Complaint IN00438721 - No deficiencies related to the allegations are cited. Survey date: July 31, 2024. Facility number: 000071 Provider number: 155150 AIM number: 100273140 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicaid: 17 Other: 15 Total: 32 The Waters of Columbia 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 Investigation of Complaints IN00437996, IN00438039, IN00438052, and IN00438721.	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
	155150	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	**640 W ELLSWORTH ST COLUMBIA CITY, IN 46725**

(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 Quality review completed August 1, 2024	F 000		