STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING -- B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/21/25 Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020 At this Emergency Preparedness survey, Waterford Crossing was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 87 and had a census of 79 at the time of this survey. Quality Review completed on 01/22/25	E 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 life safety survey . 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/21/25 Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020 At this Life Safety Code survey, Waterford Crossing was found not in compliance with Requirements for Participation in	K 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 life safety survey . Please accept this plan of correction as the provider's credible statement of compliance. With this, we the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Plantinga	Executive Director	02/04/2025

Any defiencystatement 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The one-story building was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 87 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled. Quality Review completed on 01/22/25		provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking	K 0324	K 0324 1. There were no negative outcomes for the alleged deficient practice that when cooking appliances are cleaned the equipment is placed back in a precise location. 2. The cooking appliances have a mark on the floor indicating the exact location. This will ensure all the appliances are where they are supposed to be line up with the fire extinguishing	02/04/2025

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	appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. The findings include: Based on observation and interview during tour of the facility with the Director of Plant Operations from 12:11 p.m. to 3:00 p.m. on 01/21/25, cooking appliances including a gas 6 burner stove with a flat-top gridle and oven, 1 deep fryer, an open flame grill, and 2 gas convection ovens were located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview at time of observation with the Director of Plant Operations, he was not aware of any method in place but stated he had ideas of how to correct the deficiency. This finding was reviewed with the Executive Director and Director of Plant Operations at the time of the exit conference. 3.1-19(b)		system. 3. The maintenance director will check on this weekly x 4 weeks, then monthly x2 to ensure the appliances are lined up. Results will be discussed at QAPI monthly x2.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire, plumbing, and/or conduit through 4 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could effect residents and staff in 4 of 5 smoke compartments. Findings include: Based on observation and interview during tour of the facility with the Director of Plant Operations from 12:11 p.m. to 3:00 p.m. on 01/21/25, the following unsealed penetrations were discovered: 1) a half inch gap around a 1 ½ inch pipe in the smoke barrier between resident rooms 212 and 214 2) a half inch gap around a 2 inch pipe in the smoke barrier between resident rooms 212 and 214 3) a 1 ½ inch gap around wire and cables in the smoke barrier between the 200 hall nurses' station and the laundry room 4) a quarter inch gap around a 2 inch pipe in the smoke barrier separating the memory care "Legacy" unit from the 300 hall Based on interview at the time of observation, the Director of Plant Operations acknowledged each of the penetrations. This finding was reviewed with the Executive Director and Director of Plant Operations at the time of the exit conference. 3.1-19(b)	K 0372	K-0372 1. No residents or staff were affected by the alleged deficient practice of the passage of wires, plumbing and or conduct through 4 of 5 smoke barrier walls. 2 .Director of Plant Ops/designee has put 4-hour fire caulk resident rooms 212-214-2 and 200 hall between nurses' station and laundry room and the smoke barrier separating the Legacy memory care from the 300 unit. 3. Director of Plant ops will check these areas once a month x 2 months and bring results to QAPI/safety meeting monthly until 100% compliance is maintained.	02/06/2025
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect staff only in 1 of 5 smoke compartments. Findings include: Based on observation and interview during tour of the facility with the Director of Plant Operations from 12:11 p.m. to 3:00 p.m. on 01/21/25, an extension cord, plugged into an electrical receptacle, was supplying power to a power strip that supplied power to a lamp and office equipment in the Assistant Admissions Coordinators office. Based on interview at the time of observation, the Director of Plant Operations agreed an extension cord was being used to supply power to a power strip and removed the extension cord at the time of observation. This finding was reviewed with the Executive Director and Director of Plant Operations at the time of the exit conference. 3.1-19(b)	K 0920	K-0920 1. No staff or residents were affected by the alleged deficit practice of an extension cord. 2. The extension cord was immediately removed. Education given verbally to all staff with offices that extension cords cannot be used. 3. The Plant ops Director and/or his designee will round and check all offices to ensure no extension cords being used 1x per week for 4 weeks. The findings will be brought to QAPI/safety meeting monthly until 100% in compliance.	02/06/2025
K 0923 SS=F Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure oxygen cylinders were properly stored in accordance with NFPA 99. NFPA 99 section 11.6.5.2 states if empty and full cylinders are stored within the same enclosure, empty	K 0923	K-0923 1. No residents or staff were affected by the alleged deficit practice of oxygen cylinder safely stored.	02/06/2025

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	cylinders shall be segregated from full cylinders. 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could effect all residents and staff. Findings include: Based on observation and interview during tour of the facility with the Director of Plant Operations from 12:11 p.m. to 3:00 p.m. on 01/21/25, the oxygen storage and transfilling room located in the 200 hall contained approximately 10 E- size oxygen cylinders and 5 liquid oxygen bulk containers. 1. Based on observation both full and empty oxygen cylinders and bulk containers were not segregated. 2. Empty cylinders and containers were not marked to avoid confusion and delay if a cylinder is needed in a rapid manner. Based on interview at time of observation, the Director of Plant Operations acknowledged empty and full oxygen cylinders and bulk containers were not segregated and no signage or other method was available to identify empty cylinders and containers. This finding was reviewed with the Executive Director and Director of Plant Operations at the time of the exit conference. 3.1-19(b)		2. The Director of Plant ops divided the room with markings on floor separating empty cylinder from full ones. Signs were posted in the oxygen room labeling which side empty cylinders go and which side full cylinders go. 3. Director of Plant ops will audit oxygen room 1x weekly x 4 weeks to ensure cylinders are on the correct side.	