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

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155582	B. WI	NG		01/08/	2025
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE		300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	_	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	lE	DATE
F 0000							
Bldg. 00							
Bldg. 00	IN00450476, IN004 IN00448896, IN004 IN00447703, IN004 IN00446753. This is Jeopardy. Complaint IN00450 related to the allegate F677. Complaint IN00449 the allegations are complaint IN00449 related to the allegate Complaint IN00449 related to the allegate Complaint IN00448 the allegations are complaint IN00448 the allegations are complaint IN00448 related to the allegate F624 and F693. Complaint IN00448 the allegations are complaint IN00447 the allegations are complaint IN00447 the allegations are complaint IN00447	2158 - Federal/State deficiencies tions are cited at F812. 2896 - Federal/State deficiencies tions are cited at F812. 2468 - No deficiencies related to cited. 2438 - Federal/State deficiencies tions are cited at F622, F623, 2271 - No deficiencies related to cited. 2703 - No deficiencies related to cited.	F 00	000	Preparation and/or execution of this plan of correction in gener or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of corre and specific corrective actions prepared and/or executed in compliance with State and Fed Laws. Facility's date of alleged compliance is 01/28/25. The facility is respectfully requesting paper compliance for all deficiencies in this POC.	al, not e et ction are deral	
	Complaint IN00447	260 - No deficiencies related to					

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0PJT11 Facility ID: 000521 If continuation sheet Page 1 of 46

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/08/2025
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the allegations are o	7101 - No deficiencies related to itted.			
	the allegations are c				
	Survey dates: Janua	rry 2, 3, 5, 6, 7 & 8, 2025			
	Facility number: 00 Provider number: 1 AIM number: 1002	55582			
	Census Bed Type: SNF/NF: 86 Total: 86				
	Census Payor Type Medicare: 2 Medicaid: 59 Other: 25 Total: 86	:			
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.			
	Quality review com	pleted on 1/14/25.			
F 0622 SS=J Bldg. 00	483.15(c)(1)(i)(ii)(ii)(ii)(ii)(ii)(ii)(ii)(ii)(2)(i)-(iii) harge Requirements			
	failed to ensure a not provided in writing, completed, and a re with continuity of c	view and interview, the facility office of discharge was discharge planning was sident's discharge was safe are ensured for 1 of 3 residents rge. (Resident E) This deficient	F 0622	The Administrator/Designee notified Resident E on 1/23/20 of Resident E's rights and offer to re-admit Resident E to the facility and offered to have the residents family member on the	ered

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 2 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155582	B. W			01/08/	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			WASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	-	an unsafe discharge when the			call, resident E declined havin	g	
		erred to a hospital waiting area			sister on the phone call. The		
		arrangements and no way to			Administrator/Designee also		
		ough enteral feedings. The			notified Resident E's responsi		
		ing of hopelessness and felt			party and informed the sisters		
	others wanted him t	to die.			the resident's intent to return t		
					the facility on 1/23/2025. Resi		
		pardy began on 12/24/24 when			E verbalized understanding of		
		ged Resident E to a hospital			information communicated. Th		
	_	Administrator and Regional			Administrator left a message f		
		notified of the immediate			the Ombudsman on 1/23/2025	ō.	
		M. on 1/6/25. The immediate			The Administrator/Designee		
		ved on 1/7/25, but the			arranged for re-admission on		
	-	nained at the lower scope and			1/24/2025. Residents E's prev		
	-	lated with no actual harm with			room was available and Resid		
	-	han minimal harm that is not			E accepted room number 30-	1.	
	immediate jeopardy	<i>I</i>			The Administrator and		
	T. 1 1 1				Interdisciplinary team including	-	
	Finding includes:				Administrator, Director of Nurs	-	
	771 1'' 1 1	C D '1 (F ' 1			Nurse Practitioner, Nurse, MD		
		for Resident E was reviewed on			and CNA met with Resident E	and	
		Resident E was admitted to the			care plans were revised on		
		from an acute care facility			1/24/2025. Facility offered to		
		repair of necrotizing			include resident representative		
	•	esident's diagnoses included,			care plan meeting including fa	imily	
		d to, status post (s/p)			members and Ombudsman.		
	-	sophagus, acute pancreatitis crosis, gastroesophageal reflux			Resident E declined these		
		erosis, gastroesopnageal reflux agitis, fistula of the stomach	1		representatives involvement in	ı	
	-	gastrostomy placement. The			meeting.		
		ostomy/jejunostomy tube (a			The Administrator/Designee	n of	
		ion of a tube placed in the	1		in-serviced the staff on the pla		
		placed in the jejunum that is			care for Resident E on or before 1/27/25.	л С	
		oon or plastic bumper in the					
		ic disc around the outside of			Courtney and Associates		
		dent was admitted with			completed an in-service on or		
					before 1/27/25 with Social		
		r enteral tube feedings and			Services, Administrator, and		
	medications. The a	NPO) except diet soda and			nursing staff on transfer and		
					discharge requirements. Staff		
	documentation indi-	cated the plan was for the	1		members completed a Post To	est	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 3 of 46

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP C 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573	RECTION (X5)
	RECTION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF COR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE A TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	
resident to receive nutrition via an enteral tube feeding in the extended care facility until a gastrointestinal surgical consult was completed in four weeks. The resident was to have a Computerized Tomography (CT) scan performed in two weeks. The surgical note indicated in January, the resident's condition was to be reevaluated, a cholecystectomy performed, surgical repair of the resident's intestinal system performed and the G/J tube removed. The Admission Minimum Data Set (MDS) assessment, completed on 11/30/24, indicated the resident was admitted for short stay rehabilitation from an acute care facility. The assessment during the assessment are indicated the resident was cognitively intact, had not displayed any mood issues or behaviors during the assessment period was dependent on staff for feeding due to requiring enteral feedings, utilized a walker and/or wheelchair for mobility needs, required moderate staff assistance for lower body dressing, applying footwear, and bathing needs, received physical and occupational therapy and did not require an active discharge plan. An Admission Care plan meeting note, completed on 11/29/24 at 11:01 A.M., indicated the resident attended the meeting and both sisters had participated via telephone. The resident was working with threapy to evaluate his ability to perform his own Activities of Daily Living (ADL) needs and the discharge goal was for the resident to discharge to an assisted living group home setting. There were no recommendations documented as a result of the care plan meeting. There was no further follow-up with discharge planning.	tanding. members the points e further dined as arge from tential to be deficient all facility eted by 25 to ensure charge and doto ensure onger ursing care cal needs urses and were wing: e ges n to family needs upon in-servicing POST Test cy of the member ete on or before I to dd post-test rk.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	PLE CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155582	B. W	B. WING		01/08/	2025
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			VASHINGTON ST		
\\\\\TEDC	C OE WAKADIIGA G	SKILLED NILIDSING EACH ITY THI	=				
WATERS	OF WARARUSA	SKILLED NURSING FACILITY, THI	=	WARAF	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		get date of 2/28/25, indicated			or Interdisciplinary Team mem		
	_	was to discharge from the			will be educated on hire/ return	n	
	-	t-term stay. The focus indicated			and competence validated du	ring	
	-	d to return home with a family			orientation.		
		were for the resident to			Any staff who fail to comply w		
		in therapy, as shown by his			the points of the in-servicing w	vill	
		peration, and to have a safe			be further educated and/or		
		ne only intervention listed for			progressively disciplined as		
	-	ist the resident and family with			indicated.		
	discharge planning	•			An Ad-Hoc QAPI meeting was	3	
		. 1 10/5/04 : 1: . 1			held by the Administrator,		
	_	as revised on 12/5/24, indicated			Interdisciplinary Team and Me		
		risk for nutritional status		Director on 1/6/25 to review and			
		othing by mouth (NPO) status		approve the Plan of Removal and			
	_	or nutritional support.		Allegation of Compliance.			
		ded, but were not limited to,			The SSD/ Designee will comp		
	-	lushes per the physician ights and laboratory values.			the Audit Tools that was creat		
	orders, monitor we	ights and laboratory values.			on 1/6/25 to include monitoring	g oi	
	During on interview	v, on 1/7/25 at 3:00 P.M.,			discharges to ensure that the facility provided adequate not	tion	
	_	ated the resident had been			and discharge planning and to		
		erapy services on 12/6/24, and			ensure that the resident no lor		
	-	nained at the facility.			required the facility's nursing of	-	
	the resident had ren	named at the facility.			daily 2x's weeks, and monthly		
	There were no nurs	sing and/or social service			5 months or until substantial	Α 3	
		rding discharge needs until a			compliance is achieved.		
		e, dated 12/23/24 at 2:35 P.M.,			The QAPI Committee will review	ew	
		1 Service Director (SSD) spoke			the audit tools on a monthly ba		
		nd, via a phone call with one of			and will determine compliance		
		s, informed the resident and			Any concerns will have been		
		icility had nothing to "skill"			addressed. If indicated, additi	ional	
		he needed to leave because his			Action Plans will be recomme		
	· ·	ot pay his bill. The resident			and/ or written by the QAPI		
		ne would be living on the			Committee. All action plans w	/ill	
		as asked to come to the facility			be monitored weekly by the		
		or some "training and the			Administrator to ensure		
	discharge." The res	ident's sister indicated she			substantial compliance.		
	was going to call th	ne "State" and bring them with			İ '		
	her.	-					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		l í	UILDING	nstruction 00	(X3) DATE COMPL 01/08/	ETED
	PROVIDER OR SUPPLIEI	R SKILLED NURSING FACILITY, TH	IE	300 N W	DDRESS, CITY, STATE, ZIP COD /ASHINGTON ST USA, IN 46573		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	Social Service Note and 12/24/2024 at attempted to leave regarding the reside. A Social Service Note indicated one of the phone message that transported to the leave refused to "take him the SSD, dated 12/2 resident wanted to speak with his doct a bus ticket out of the There was no docur indicated the reside communication about he was informed he. There was no docur indicate the SSD on provide any written for discharge plann continuity of care to the physician's order to discharge the During an interview Medical Director in notified nor had any discharge for Reside A Nursing Progress P.M., indicated the reprogress Note, date	but wanting to discharge until a would have to leave. mentation in the record to any other staff attempted to a notice of discharge, services ing, or services to ensure to the resident or family. Mers for Resident E lacked and the resident from the facility. It is a simple of the resident of the property of the resident from the facility. It is a simple of the resident of the property of the		TAG	DEFICIENCY)		DATE
	I		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 6 of 46

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2025
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	300 N V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	A Resident Dischar 12/24/24 by the Dir indicated Resident I Home/Community is "sister/family to dri was given discharge with all of his perso education on his gas was quoted as statir off at [name of loca [gastronomy tube] or resources were lister marked. Additional follows, "Resident in no longer skill his saddress so home he in the from a nearby communiformed the facility local hospital and cout" of the long-tern "dumped" him off a nurse documented sand informed him the from the facility bechim off" and his sis him." She indicated go to the local hospital ed 38 P.M. for feedin Room (ER) note in with complaints, " [name of facility] rehave no place to go	ge Summary, completed on ector of Nursing (DON),			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 7 of 46

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155582	B. W	ING		01/08	/2025
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			VASHINGTON ST		
WATERS	S OF WAKABLISA	SKILLED NURSING FACILITY, TH	_		RUSA, IN 46573		
WAILING	OI WARAROSA (SKILLED NORSING I ACILITI, III	<u> </u>	WAINAI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		eeze my internal organsI need					
		The note indicated the					
		ated and, "differential					
	_	ration include social situation					
	_	less tonight on Christmas Eve.					
		care coordinators have left for					
		r 5 p.m" The case was					
		house supervisor and there					
		ed for an inpatient stay. He was					
	safe to discharge.						
	A (NI	1) FD4 1-4- 1 12/25/24					
	` *	(al) ER note, dated 12/25/24,					
		ent presented to the ER with his					
		had a history of complex crotizing pancreatitis with J					
	1	complained of feeling					
	_	s current situation, as he was					
	_	discharged from a nursing					
		o. The sister indicated she had					
		one to try to get help. The					
		ne was tube dependent and had					
		gs for the past two days and					
	1	hout any equipment. The note					
		nt is feeling hopeless because					
		one in the state of Indiana					
		in a ditch and diePatient is					
		nd hopeless like he would be					
		o not feel comfortable					
		ome because he has no way to					
		he (facility name) was					
	-	cated the resident was					
		ER yesterday because he had					
	_	ly would not pick him up. He					
		any feedings and there were					
	_	ments that staff were aware of					
		the discharge summary.					
		-					
	A (Name of Hospit	al) Discharge Note indicated					
	_	at the hospital on 12/25/24 at					
		aking suicidal statements. The					
	I		1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 8 of 46

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

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 01/08	LETED
WATERS	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	300 N	ADDRESS, CITY, STATE, ZIP COE WASHINGTON ST RUSA, IN 46573)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ILD BE ROPRIATE	(X5) COMPLETION DATE
	documentation indi the acute care facility discharged to the lost feedings to be contisticated in January resident was dischated facility but was horn his tube feedings. To unable to go to any the area due to the type sented to the em "hopeless." The em the resident was not and had complex so evaluated in the em due to the suicidal of deemed not actively hopeless" due to his admitted to the acut including, but not lie extremities with any continued need for feedings for nutriticals on had bilateral lost thrombosis (a condictor forms in a vein and was treated with The resident was did 1/3/25. During a confidential 1/5/2025 at 11:30 A the resident and his on 12/23/24 that the "cut" him and woult resident to stay at the indicated the reside	cated the resident had been in ty for a prolonged stay, was ing-term care facility with tube mued, and a GI obysician follow-up to have a 2025. The note indicated the reged from the long-term care meless with nothing set up for the note indicated he was of the homeless shelters in mube feeding, and so he had ergency department feeling ergency room note indicated at able to take in nutrition orally ocial issues. The resident was ergency room by psychiatry comments he had made and a validation. The resident was the care facility with diagnoses imited to, cellulitis of the lower tibiotic therapy ordered and jejunal nocturnal (night) tube onal needs. On admission, he ower extremity deep vein into that occurs when a blood deep inside a part of the body) he heparin (a blood thinner). scharged from the hospital on all telephone interview, on a.M., the interviewee indicated family members were informed the resident's insurance had do not pay the bill for the need facility. The complainant int was not given any prior mentation regarding an				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 9 of 46

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

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155582	A. BUILDING B. WING	00	COMPLETED 01/08/2025
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	4:10 P.M., she indice Care Plan Meeting, informed her the distresident to go to a gindicated she had in resident did not have for a group home adadmit someone to a months to complete for the resident to dibut when she notified resident's need to be sisters indicated the resident the hospital because indicated she told the had to leave because from therapy service "skilled" service for payor source or if the resident's insurance change, the SSD incontacted the resident not aware of any "curinsurance" or any N. Medicare/Medicaid provided for Resident was given a notice, the SSD indithe form. When ask been informed of Reto the hospital and it faxed to the local honursing would have things and she was a had been given to the Resident E. When a	with the SSD, on 1/5/25 at sated during the Admission the resident's sisters had scharge goal was for the roup home setting. She formed the sisters that the e any qualifying diagnoses dission and the process to group home took up to six. She indicated the plan was discharge to his sister's home and them on 12/23/24 of the edischarged on 12/24/24, both could not stay with them. She has car was there. The SSD de resident and his sisters he each had been discharged es and the facility had no him. When asked about his dere was a letter from the of his notice of eligibility dicated she did not pay be payor sources and she was not little the facility had no him. When asked if the a written 30-day discharge cated she was not familiar with each of the local hospital had esident E's desire to be taken of any paperwork had been despital, the SSD indicated taken care of those types of dinsure if any communication are local hospital regarding sked if there were any more notes or documentation for			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 10 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155582	B. WING 01/08/2025				
			1	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		D indicated the only notes were					
	-	n the electronic record					
	progress notes.						
	During on intervious	y on 1/6/25 at 11:00 A M tha					
	-	w, on 1/6/25 at 11:00 A.M., the had completed the discharge					
		ons for Resident E on 12/24/24.					
		ident was being discharged					
	due to "an insurance	6 6					
		the facility had nothing to					
		DON had attempted to teach					
	him how to use his	PEG tube, but he refused all					
	teaching and refuse	d to take any tube feeding					
	with him because he	e was going straight to the					
	-	tube removed. When asked if					
	-	tified of his desire to go to the					
	-	facility transfer set up with the					
	-	stated "No, he was being					
	-	ospital parking lot because					
		car was located." The DON					
		ent his prescriptions for					
		al pharmacy, but the resident					
	_	bably not going to go get his e he did not have any money					
		ated she had sent a three-day					
		ons with him and gave him					
	* * *	medications. The DON					
		e SSD and the Assistant					
	-	(ADON) completed discharge					
	_	nts and she was unsure what					
		completed for Resident E prior					
		m the facility. The week of his					
	discharge, the ADO	N was on vacation and the					
	DON was not sure	what planning the SSD had					
	documented.						
	During on intermier	v, on 1/6/25 at 2:39 P.M., the	1				
	-	eated the resident was admitted					
		pilitation to home. She					
		ras to his sister's home in					
	anderstood nome w	as to mis sister s nome in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 11 of 46

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SU COMPLET 01/08/20	ED		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST HE WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE		
	otherwise. The Adridischarge the resided Michigan was docu was no documentat service or nursing particles and discharge because he therapy services and "skill" him for just indicated that the refrom the facility be with his family. Ho service and/or nursithe resident's desire on 12/24/24 or any holidays document family's desire for he holidays. The Aresident's sister in Tinsisting the resident hospital. However, Administrator had precorded phone meclearly stated neither to take care of the rishe was very upset out" before Christm During an interview transportation staff 1/6/25 at 4:00 P.M. Resident E off by he the local hospital are hospital carrying his of any paperwork set.	ated the resident needed to be had been discharged from discharged from discharged from discharge fore the holidays to spend them wever, there was no social ng progress note to support to discharge from the facility motes leading up to the ng the resident and/or his him to be discharged prior to diministrator indicated the fexas had left a phone message at be discharged to the local on 1/6/24 at 4:01 P.M., the played part of the audible ssage and the resident's sister for she nor her sister were able esident, he was homeless, and the facility was "kicking him has." With the facility member, Employee 41, on the indicated she had dropped imself at the main entrance to had he had walked into the se suitcase. She was not aware ent to the hospital.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 12 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPLETED	
		155582	B. WING			01/08/	2025
			ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THE			RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
	discharge was safe.						
	During an interview	y, on 1/7/25 at 12:40 P.M., the					
	-	ed her brother, herself and their					
	other sister were inf	Formed on 12/23/24 that the					
	resident needed to d	lischarge because his					
		t continue to pay. She					
		e family nor the resident were					
		ce and offered any assistance					
		f discharge. The facility was					
		er their sister nor her could get					
		at of state. He was taken to the					
		d off. None of them knew					
		d do. The resident was seen in					
		and was discharged. She					
		ty guard at the hospital was so ent had no place to go, the					
	-	ht him a one-night stay at a					
		illy did not see the resident					
		n he was taken back to the					
		ly. He was subsequently					
		pital on 12/25/24. She indicated					
	-	ible ordeal for her brother. He					
		hospital again with life					
	threatening concern						
	Resident E's govern	ment-provided insurance					
	eligibility forms ind	licated Resident E was					
		erm care skilled care through					
	* *	oval dates were given for					
	-	ods and Resident E's stay had					
	* *	his admission through					
	12/26/24 at the time	of his discharge on 12/24/24.					
	The facility policy	and procedure, titled "Transfer					
		ey and Procedure" provided by					
	_	s current on 1/6/25 at 9:05					
		following: "2. Non-emergency					
		ges not within the same					
		l receive notice 30 days before					
	231 miles facility will	1122110 Hones 50 days before					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 13 of 46

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155582		ſ <i>′</i>	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 01/08/	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, TH			<u> </u>	300 N W	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST USA, IN 46573	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	transfer or discharg resident/responsible will include the foll resident has the right State Department or phone number of the address and telephote Term Care Ombuds resident may appear the Department of Inotified of the transmay remain in the findetermination or 34 that the transfer is a provide provisions and the provide provisions are attending physician discharge order. The acceptable Discharung the resident of the resident of the resident of the resident or the resident o	e. Notice will be given to the party. 3. The written notice owing: a. A statement that the at to appeal the section to a Health including a current be Department, b. The name, ne number of the State Long sman,d. A state that, if the latter transfer or discharge to Health within 10 days of being fer/discharge 4. The resident facility pending an appeal days if the department agrees propriate6. The facility will for continuity of care and in ations a care plan meeting will propriate parties to determine a fischarge to Home or lower level ent or family will be esident's medications 2. The is required to write a dephone orders are rege Against Medical Advice 1. wishes to go home or the esponsible Party wishes to take and the attending physician acharge order a 'Discharge divice' form must be signed by esident's representative and record. 2. No transfer form facility should determine the appropriate State agencies if is a concernEmergency physician order for transfer. If the diam is not available, contact or. 3. If the Medical Director is cet the Director of Nursing5. transfer. 6. Explain transfer and		TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 14 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155582	B. WI	NG		01/08	/2025
NAME OF P	DOUDED OF CUIPNITE			STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .		300 N V	VASHINGTON ST		
	OF WAKARUSA S	SKILLED NURSING FACILITY, THI	Ξ	WAKAR	RUSA, IN 46573		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	applicable send the	nt and/or representative, if					
		Bed hold notice with the					
	_	esentative or person(s)					
	-	Place the facility copy in the					
	-	omplete the Resident Transfer					
		of any portion of the heath					
	_	r care of resident (E.g.					
	•	History & Physical, chest					
	-	n information, any pertinent lab					
	1 / /	original of transfer form and					
	-	ecord that was copies with the					
		second copy of the portions					
		to the facility copy of the					
		the third copy of the transfer					
	form to the DON	"					
	The immediate icom	pardy that began on 12/24/24					
		7/25, after the facility					
		ete audit of all discharges in the					
		nd educated all licensed					
		dministrator and social service					
	-	discharge policy. The					
		ained at the lower scope and					
	-	lated, no actual harm with					
	-	han minimal harm that is not					
	immediate jeopardy	, because the facility needed to					
		n was effective by auditing					
		owing up on staff education					
	with further educati	on for the SSD.					
	This citation relates	to Complaint IN00448438.					
	3.1-12(a)(3)						
	3.1-12(a)(4)						
	3.1-12(a)(5)(B)						
	3.1-12(a)(6)(A)						
	3.1-12(a)(7)						
	3.1-12(a)(18)						
	3.1-12(a)(19)						
1	i		1	1			1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 15 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155582	B. W	ING		01/08	/2025	
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	lE	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDENCE N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	3.1-12(a)(20) 3.1-12(a)(21) 3.1-12(a)(22)							
F 0623	483.15(c)(3)-(6)(8))						
SS=D	Notice Requireme	nts Before						
Bldg. 00	Transfer/Discharg							
		view and interview, the facility	F 0	623	It is the policy of this facility to		01/28/2025	
		otice of discharge was			ensure a notice of discharge in			
	-	, prior to a facility-initiated			provided in writing prior to a fa	cility		
	_	residents reviewed for			initiated discharge.			
	discharge. (Resider	nt E)			Resident E re-admitted to the			
					facility on 1/24/2025.			
	Finding includes:				All residents who reside in the			
		6 B 11 (B			facility have the potential to be			
		for Resident E was reviewed on			affected by the alleged deficie			
		Resident E was admitted to the			practice. Therefore, this plan of			
	-	24 from an acute care facility			correction applies to all reside	nts		
	following surgical r	sident's diagnoses, included,			of the facility.			
	_	to, status post (s/p)			Director of Nursing /Designee in-serviced on or before 1/27/2	DE all		
		sophagus, acute pancreatitis			nursing staff and social service			
	_	rosis, gastroesophageal reflux			on the transfer/discharge poli			
		gitis, fistula of the stomach			and entering orders to dischar	•		
	*	gastrostomy placement. The			resident, documentation of	gc a		
		ed with physician's orders for			discharge planning and educa	tion		
		s and nothing by mouth			provided to resident and family			
		oda and medications. The			provide written notice of disch	-		
		locumentation indicated the			documentation to be sent with	_		
	plan was for the res	ident to receive nutrition via			resident if discharging to hosp			
	an enteral tube feed	ing in the extended care			Additionally, any staff that fails			
	facility until a gastro	ointestinal surgical consult			comply with the points of this			
	was completed in fo	our weeks. The resident was to			in-service will be further educa	ated		
	have a Computerize	ed Tomography (CT) scan			and/or disciplined as indicated	l.		
	-	eeks. The surgical note			The Director of Nursing/Design	nee		
		, the resident's condition was			will audit residents discharged	or		
		cholecystectomy performed,			transferred to the hospital for			
		e resident's intestinal system			physician order, documentation			
	performed and the O	G/J tube removed.			education, written transfer not			
					given to resident or representa	ative,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

1

If continuation sheet Page 16 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/08/2025 155582 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Admission Minimum Data Set (MDS) documentation sent with resident assessment, completed on 11/30/24, indicated the upon discharge or transfer to resident was admitted for short stay rehabilitation hospital 5 times a week x 4 from an acute care facility. weeks, then 3 times a week x 4 weeks, then once a week x 4 An Admission care plan meeting note, completed months. If the facility is within on 11/29/24 at 11:01 A.M., indicated the resident 95% compliance at the end of 6 had attended the meeting and both sisters had months, the monitoring will be participated via telephone. The resident was stopped. Results of the monitoring working with therapy to evaluate his ability to will be reviewed at the monthly perform his own Activities of Daily Living (ADL) QAPI meeting. Any concerns will needs and the discharge goal was for the resident have been addressed. However, to discharge to an assisted living group home any patterns will be identified. Any setting. There were no recommendations needed Action Plan will be written documented as a result of the care plan meeting by the QAPI committee. Any and no follow-up for discharge planning. written Action Plan will be monitored by the Administrator A Discharge Care Plan, dated 12/16/24 with a weekly until resolved. target date of 2/28/25, indicated the resident's goal was to discharge from the facility after short-term stay. The focus indicated the resident planned to return home with a family member. The goals were for the resident to actively participate in therapy, as shown by his attendance and cooperation, and to have a safe discharge home. The only intervention listed for the plan was to assist the resident and family with discharge planning. There was no documentation in the clinical record for discharge planning. There were no nursing and/or social service progress notes regarding discharge needs until a Social Service Note, dated 12/23/24 at 2:35 P.M., indicated the Social Service Director (SSD) spoke with the resident and, via a phone call with one of the resident's sisters, informed the resident and his sister that the facility had nothing to "skill" the resident on, so he needed to leave because his insurance would not pay his bill. The resident informed the SSD he would be living on the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 17 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPLETED	
		155582	B. WIN	G		01/08/	2025
			\vdash	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THE	<u> </u>		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		as asked to come to the facility					
		or some "training and the					
	-	dent's sister indicated she					
	was going to call the	e "State" and bring them with					
	her.						
	A Social Service no	te, dated 12/24/24 at 2:25 P.M.,					
		resident's sisters had left a					
		the resident was to be					
		ocal hospital because she					
	-	in." A follow-up entry from					
		4/2024 at 2:19 P.M., indicated					
	· · ·	to go to the local hospital to					
		ors and then he planned to get					
	-	ne state to go to his sister's					
	house.						
		Note, dated 12/24/24 at 4:12					
		resident was transported by					
		ter to the local hospital as					
		ident. However, a Nursing					
	_	d 12/24/24 at 4:14 P.M.,					
	indicated the resider	nt was "discharged to home."					
	A Resident Dischar	ge Summary, completed on					
		ector of Nursing (DON),					
	indicated Resident I	- ', '					
		accompanied by his family -					
	"sister/family to dri	ve him home." The resident					
	was given discharge	e instructions and discharged					
	with all of his perso	nal belongings but declined					
		stronomy tube. The resident					
	*	g "I am going to be dropped					
		l hospital] and they will take it					
		out for me." No community					
		d and 'None Needed" was					
		comments on the form were as					
		s discharging because we can					
		ervices. He has no forwarding					
	address so home he	alth cannot be scheduled."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 18 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155582	B. WI	NG		01/08/	2025
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	2			ASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E		USA, IN 46573		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	form section indicated a Bed					
		ovided but there was no signed					
	copy of the form lo	cated in the clinical record.					
	The physician's ord	ers for Resident E lacked an					
		he resident from the facility.					
		·					
	There was no docur	mentation in the record to					
	indicate the SSD or	any other staff attempted to					
	provide any prior w	ritten notice of discharge.					
		ment-provided insurance					
		licated Resident E was					
		erm care skilled care through					
		oval dates were given for					
	-	iods and Resident E's stay had					
		n his admission through e of his discharge on 12/24/24.					
	12/20/24 at the time	e of his discharge on 12/24/24.					
	During a confidenti	al telephone interview, on					
	1/5/2025 at 11:30 A	A.M., the interviewee indicated					
	indicated the reside	nt and his family members					
	were informed on 1	2/23/24 that the resident's					
	insurance had "cut"	him and would not pay the					
		to stay at the facility. The					
	-	ted the resident was not given					
		d/or documentation regarding					
	an impending disch	arge.					
	During on intermier	wwith the SSD on 1/5/25 of					
	-	w with the SSD, on 1/5/25 at cated during the Admission					
	· ·	the resident's sisters had					
	-	scharge goal was for the					
		group home setting. She					
		formed the sisters that the					
		re any qualifying diagnoses					
		dmission and the process to					
		group home took up to six					
		e. She indicated the plan was					
		ischarge to his sister's home					
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 19 of 46

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155582			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/08/2025				
	PROVIDER OR SUPPLIER	R SKILLED NURSING FACILITY, THI	<u> </u>	300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ed them on 12/23/24 of the					
		e discharged on 12/24/24, both					
		could not stay with them. She					
		ent asked to be discharged to e his car was there. The SSD					
	_	he resident and his sisters he					
		se he had been discharged					
		es and the facility had no					
		r him. When asked about his					
		here was a letter from the					
		of his notice of eligibility					
		dicated she did not pay					
	attention to resident	t's payor sources and she was					
	not aware of any "c	eut" letters (from Resident E's					
	insurance) or any N	IOMNC (Notice of					
	Medicare/Medicaid	Non-Coverage form) being					
	provided for Reside	ent E. When asked if the					
	_	a written 30-day discharge					
		licated she was not familiar with					
		ted if the local hospital had					
		esident E's desire to be taken					
	_	if any paperwork had been					
		ospital, the SSD indicated					
	_	e taken care of those types of					
		unsure if any communication					
	_	he local hospital regarding					
		asked if there were any more					
		notes or documentation for D indicated the only notes were					
	· ·	n the electronic record					
	progress notes.	if the electronic record					
	progress notes.						
	During an interview	v, on 1/6/25 at 11:00 A.M., the					
	_	had completed the discharge					
		ons for Resident E on 12/24/24.					
	She thought the res	ident was being discharged					
	due to "an insuranc	_					
		the facility had nothing to					
		e DON had attempted to teach					
	him how to use his	PEG tube, but he refused all					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PJT11

Facility ID: 000521

If continuation sheet Page 20 of 46

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2025		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION d to take any tube feeding	PR	ID EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	with him because h hospital to have the the hospital was not hospital, and a inter hospital, the DON s discharged to the hot that was where his indicated usually the Director of Nursing planning for resider planning had been of to his discharge from discharge, the ADODON was not sure documented. The Doshort-term residents notice. During an interview Administrator indict for short-term rehat needed to discharge discharged from the was not able to "skit tube. She then indict to discharge from the was not able to "skit tube. She then indict to discharge from the was not able to "skit tube. She then indict to discharge from the was not able to "skit tube. She then indict to discharge from the was not able to "skit tube. She then indict to discharge from the vasing the resident facility on 12/24/24 holidays document family's desire for he holidays. The Aresident's sister in Tinsisting the resider hospital. However, Administrator had precorded phone medical processing the resider hospital. However, Administrator had precorded phone medical processing the processing the resider hospital.	d to take any tube feeding e was going straight to the tube removed. When asked if tified of his desire to go to the facility transfer set up with the stated "No, he was being ospital parking lot because car was located." The DON e SSD and the Assistant (ADON) completed discharge his and she was unsure what completed for Resident E prior in the facility. The week of his to was on vacation and the what planning the SSD had doon indicated generally, is were not given a 30-day. To on 1/6/25 at 2:39 P.M., the ated the resident was admitted of because he had been crapy services and the facility lil" him for just his gastronomy eated that the resident desired he facility before the holidays his family. However, there was do'r nursing progress note to d's desire to discharge from the for any notes leading up to the night he resident and/or his him to be discharged prior to diministrator indicated the fexas had left a phone message at be discharged to the local on 1/6/24 at 4:01 P.M., the olayed part of the audible ssage and the resident's sister or she nor her sister were able						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 21 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	ETED
		155582	B. WING			01/08	/2025
			CTD	CET A	DDDECC CITY CTATE ZID COD		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS OF WAKARUSA SKILLED NURSING FACILITY, TH					VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, THI	= VVA	KAR	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
		esident, he was homeless, and					
		the facility was "kicking him					
	out" before Christm	nas.					
	During an interview						
	_	member, Employee 41, on					
		, she indicated she had dropped					
	1	imself at the main entrance to					
	_	nd he had walked into the					
		s suitcase. She was not aware					
	of any paperwork so	ent to the hospital.					
	TEL C '11', 1'	1 1 21 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		and procedure, titled "Transfer					
	_	cy and Procedure" provided by					
		s current on 1/6/25 at 9:05					
		following: "2. Non-emergency					
		ges not within the same					
	I	Il receive notice 30 days before					
	_	e. Notice will be given to the e party. 3. The written notice					
		owing: a. A statement that the					
		nt to appeal the section to					
		f Health including a current					
	_	e Department, b. The name,					
		one number of the State Long					
	1	sman,d. A state that, if the					
		I the transfer or discharge to					
		Health within 10 days of being					
		efer/discharge 4. The resident					
		acility pending an appeal					
	1 -	days if the department agrees					
		appropriate6. The facility will					
		for continuity of care and in					
		nations a care plan meeting will					
		propriate parties to determine a					
		ischarge to Home or lower level					
	_	ent or family will be					
		esident's medications 2. The					
		is required to write a					
	discharge order. Te	-					
	1		1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 22 of 46

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582			l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/08/	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE	
	When the resident or resident's family/Rother resident home a refuses to give a dis Against Medical Acther resident or their placed in the health completed 4. The need to contact the the resident's safety Transfer: 1. Obtain the attending physic emergency, contact the alternate physic the Medical Director available, contact Call ambulance for reason to the reside applicable send the Transfer/Discharge resident and/or represent the althrecord. 7. Cofor make 2 copies or record necessary for Physician's Orders, x-ray, Immunization work, etc) 8. Send of portions of health resident, attach the of the health record transfer form. Give form to the DON	/Bed hold notice with the resentative or person(s) 2. Place the facility copy in the complete the Resident Transfer of any portion of the heath or care of resident (E.g. History & Physical, chest on information, any pertinent lab original of transfer form and ecord that was copies with the second copy of the portions to the facility copy of the the third copy of the transfer						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PJT11

Facility ID: 000521

If continuation sheet Page 23 of 46

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	00	COMPL	ETED
		155582	B. WI	NG		01/08/	2025
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE		300 N V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(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 APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0624 SS=D Bldg. 00	was no signed copy located in the reside discharge from the form the following signal in the reside discharge from the following signal in the followi	to Complaint IN00448438. fe/Orderly Transfer/Dschrg riew and interview, the facility	F 06	524	It is the policy of the facility to		01/28/2025
	Based on record review and interview, the facility failed to ensure preparation and orientation for a resident's discharge was completed to minimize anxiety and ensure a safe and orderly discharge from the facility for 1 of 3 residents reviewed for discharge planning. (Resident E) Finding includes: The clinical record for Resident E was reviewed on 1/5/25 at 2:00 P.M. Resident E was admitted to the facility on 11/23/24 from an acute care facility following surgical repair of necrotizing pancreatitis. The resident's diagnoses included, but were not limited to, status post (s/p) perforation of the esophagus, acute pancreatitis with uninfected necrosis, gastroesophageal reflux disease with esophagitis, fistula of the stomach and duodenum, and gastrostomy placement. The resident was admitted with physician orders for enteral tube feedings and nothing by mouth (NPO) except diet soda and medications. The acute care transfer documentation indicated the plan was for the resident to receive nutrition via an enteral tube feeding in the extended care facility until a gastrointestinal surgical consult				provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Resident E re-admitted to the facility on 1/24/2025. All residents have the potential be affected by the cited practice therefore, this plan of correction applies to all residents that resing the facility. DON/Designee on or before 1/27/25 in-serviced all nursing and social services on the transfer/discharge policy and entering orders to discharge a resident, documentation of discharge planning and educate provided to resident and family provide written notice of discharded documentation to be sent with resident if discharging to hospit Additionally, any staff that fails comply with the points of this	om I to ee, n ide staff tion , arge, tal.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PJT11 Facility ID: 000521

If continuation sheet Page 24 of 46

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	A. B	IULTIPLE CO UILDING 'ING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2025	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, T	HE.	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF Was completed in the have a Computerize performed in two windicated in January to be reevaluated, a surgical repair of the performed and the resident of the performed and the resident of the performed and the performed and the performed and the meeting participated via teleworking with the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and the discharge to an allocation of the performed and t	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Our weeks. The resident was to ed Tomography (CT) scan reeks. The surgical note of the tresident's condition was cholecystectomy performed, re resident's intestinal system G/J tube removed. Inimum Data Set (MDS) reed on 11/30/24, indicated the red for short stay rehabilitation facility. The assessment reaction was dependent on recent period, was dependent on recent period	HE			cated d. ferred order, o dent 4 f 6 e toring ly will ver, . Any ritten	(X5) COMPLETION DATE
	There was no furth planning. A Discharge care p	sult of the care plan meeting. er follow-up with discharge lan for Resident E, dated get date of 2/28/25, indicated					

FORM CMS-2567(02-99) Previous Versions Obsolete

the resident's goal was to discharge from the facility after a short-term stay. The focus indicated

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 25 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	LETED
		155582	B. WIN	IG		01/08	/2025
			- Т	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			VASHINGTON ST		
\/\ATEDS	COE WAKABIISA S	SKILLED NURSING FACILITY, THE	_		RUSA, IN 46573		
WATERS	O WANARUSA S	DIVILLED NOTOING FACILITY, THE		A A VAIVA D	, IN 40070		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	d to return home with a family					
	_	were for the resident to					
		in therapy, as shown by his					
		peration, and to have a safe					
	-	e only intervention listed for					
	-	st the resident and family with					
	discharge planning.						
		ing and/or social service					
		rding discharge needs until a					
		e, dated 12/23/24 at 2:35 P.M.,					
		Service Director (SSD) spoke					
		d, via a phone call with one of					
		s, informed the resident and					
		cility had nothing to "skill"					
		ne needed to leave because his					
		t pay his bill. The resident					
		ne would be living on the					
		as asked to come to the facility					
		or some "training and the ident's sister indicated she					
	_						
		e "State" and bring them with					
	her.						
	A Social Service N	ote, dated 12/24/24 at 2:25 P.M.,					
		e resident's sisters had left a					
		the resident was to be					
		ocal hospital because she					
	-	n in." A follow-up entry from					
		24/24 at 2:19 P.M., indicated the					
		go to the local hospital to					
		ors and then he planned to get					
		he state to go to his sister's.					
		mentation in the record that					
	indicated the reside						
		out wanting to discharge until					
		would have to leave.					
	ne was informed lie	would have to leave.					
	The physician's ord	ers for Resident E lacked an					
		he resident from the facility.					
		,	1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 26 of 46

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155582	B. W	ING		01/08	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			VASHINGTON ST		
WATERS	S OF WAKARLISA S	SKILLED NURSING FACILITY, THE	=		RUSA, IN 46573		
		S.G.E.E.D. NO.C.III (INC. ET 1 , ITIL			10070		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1/6/05 + 2.26 73.5 - 4					
	· ·	v, on 1/6/25 at 3:36 P.M., the					
		dicated he had not been					
		y record of ordering a					
	discharge for Resid	ent E.					
	A Murcina Dramasa	Note dated 12/24/24 at 4:12					
		Note, dated 12/24/24 at 4:12 resident was transported by					
		ter to the local hospital as					
		sident. However, a Nursing					
		d 12/24/24 at 4:14 P.M.,					
		nt was "discharged to home."					
	maioaica inc reside	in was discharged to nome.					
	A Resident Dischar	ge Summary, completed on					
		rector of Nursing (DON),					
	indicated Resident	<u> </u>					
		accompanied by his family -					
	-	ve him home." The resident					
		e instructions and discharged					
	-	onal belongings but declined					
	_	stronomy tube. The resident					
		ng "I am going to be dropped					
	-	ll hospital] and they will take it					
	-	out for me." No community					
		ed and 'None Needed" was					
	marked. Additiona	l comments on the form were as					
		is discharging because we can					
		ervices. He has no forwarding					
		alth cannot be scheduled."					
		al) Physician's Note indicated					
		at the hospital on 12/25/24 at					
		king suicidal statements. The					
		cated the resident had been in					
		ty for a prolonged stay, was					
	_	ng-term care facility with tube					
	feedings to be conti						
		nysician follow-up to have					
		2025. The resident was					
	discharged from the	e long-term care facility but					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 27 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155582	B. WI	NG		01/08	/2025
			•	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	E	1	RUSA, IN 46573		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nothing set up for his tube					
	_	indicated he was unable to go					
	-	ess shelters in the area due to					
		id so he had presented to the					
		ent feeling "hopeless." The					
		ote indicated the resident was					
		utrition orally and had					
	complex social issu	es.					
	During a confidenti	al telephone interview, on					
	~	A.M., the interviewee indicated					
		family members were informed					
		e resident's insurance had					
		d not pay the bill for the					
		ne facility. The resident was					
	-	notice and/or documentation					
	regarding an impen						
	During an interview	w with the SSD, on 1/5/25 at					
	-	cated during the Admission					
		the resident's sisters had					
	-	scharge goal was for the					
		group home setting. She					
		aformed the sisters that the					
		e any qualifying diagnoses					
		dmission and the process to					
		group home took up to six					
		e. She indicated the plan was					
	-	ischarge to his sister's home					
		ed them on 12/23/24 of the					
		e discharged on 12/24/24, both					
		could not stay with them. She					
		nt asked to be discharged to					
		e his car was there. The SSD					
	_	ne resident and his sisters he					
	had to leave becaus	e he had been discharged					
	from therapy servic	es and the facility had no					
		r him. When asked about his					
	payor source or if th	here was a letter from the					
		of his notice of eligibility					
			1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 28 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 01/08/2025				
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST HE WAKARUSA, IN 46573					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING DIFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE COMPLETION			
TAG	change, the SSD indattention to resident not aware of any "cinsurance) or any Nedicare/Medicaid provided for Resider resident was given a notice, the SSD indathe form. When ask been informed of R to the hospital and if faxed to the local hoursing would have things and she was had been given to the Resident E. When a discharge planning Resident E, the SSI the ones provided in progress notes. During an interview DON indicated she forms and instructions the shought the residue to "an insurance rehabilitation-wise," "skill" him on. The him how to use his teaching and refuse with him because hospital to have the the hospital was not hospital, and a interhospital, the DON sedischarged to the hospital was where his discharged to a local medicated she had seemedication to a local medicated she had seemedicated she had seem	Non-Coverage form) being and E. When asked if the a written 30-day discharge icated she was not familiar with ed if the local hospital had esident E's desire to be taken frany paperwork had been ospital, the SSD indicated taken care of those types of unsure if any communication he local hospital regarding asked if there were any more notes or documentation for D indicated the only notes were in the electronic record 17, on 1/6/25 at 11:00 A.M., the had completed the discharge ons for Resident E on 12/24/24. Ident was being discharged	TAG	DEFICIENCY)	DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 29 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTI A. BUILD B. WING		nstruction 00	(X3) DATE SURVEY COMPLETED 01/08/2025		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	30	STREET ADDRESS, CITY, STATE, ZIP CO 300 N WASHINGTON ST WAKARUSA, IN 46573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	medications because for them. She indicated supply of medication instructions for the indicated usually the Director of Nursing planning for resider planning had been of to his discharge from discharge, the ADO DON was not sure adocumented. The During an interview when he was discharge (rehabilitation) served services and instruction of the planning and interview administrator indicated for short-term rehabilitation, as the resident of the planning and interview administrator indicated for short-term rehabilitation, as the resident of the planning and discharge the resident of the planning and discharge because the from the facility betwith his family. However, it is the resident's desire on 12/24/24 or any holidays documentation in the resident's desire on 12/24/24 or any holidays documentation.	e he did not have any money ated she had sent a three-day ons with him and gave him medications. The DON e SSD and the Assistant (ADON) completed discharge ats and she was unsure what completed for Resident E prior on the facility. The week of his on was on vacation and the what planning the SSD had ON indicated generally, short not given a 30 day notice, but have been given a NOMNC arged from rehab ices. She was not sure if the form. If on 1/6/25 at 2:39 P.M., the ated the resident was admitted oilitation to home. She as to his sister's home in sident was homeless ministrator thought the plan to the to his sister's home in mented on 12/4/24, but there ion of this plan in the social					DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 30 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	ETED
		155582	B. WING			01/08/	2025
			СТ	DEETA	DDDESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\		SKILLED MUDSING FACILITY TH			VASHINGTON ST		
WATERS	OF WARARUSA S	SKILLED NURSING FACILITY, TH		ANAR	RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
	the holidays. The A	dministrator indicated the					
	resident's sister in T	Cexas had left a phone message					
	insisting the resider	nt be discharged to the local					
	hospital. However,	on 1/6/24 at 4:01 P.M., the					
	Administrator had p	played part of the audible					
	recorded phone mes	ssage and the resident's sister					
	clearly stated neither	er she nor her sister were able					
	to take care of the re	esident, he was homeless, and				ļ	
	she was very upset	the facility was "kicking him					
	out" before Christm	nas.					
	During an interview	-					
	_	member, Employee 41, on					
		, she indicated she had dropped					
	I -	imself at the main entrance to					
	_	nd he had walked into the					
		s suitcase. She was not aware					
	of any paperwork so	ent to the hospital.					
		and procedure, titled "Transfer					
	_	ey and Procedure" provided by					
		s current on 1/6/25 at 9:05					
	l '	following: "2. Non-emergency					
		ges not within the same					
	I	Il receive notice 30 days before					
	_	e. Notice will be given to the				ļ	
		e party. 3. The written notice					
		owing: a. A statement that the					
	_	nt to appeal the section to					
		f Health including a current					
	1 ~	e Department, b. The name,					
	_	one number of the State Long					
		sman,d. A state that, if the				ļ	
		the transfer or discharge to				ļ	
	_	Health within 10 days of being				ļ	
		efer/discharge 4. The resident				ļ	
	1 -	acility pending an appeal				ļ	
		days if the department agrees				ļ	
		appropriate6. The facility will				ļ	
	provide provisions	for continuity of care and in				ļ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 31 of 46

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 01/08/	ETED
	PROVIDER OR SUPPLIER S OF WAKARUSA S	SKILLED NURSING FACILITY, TH	<u> </u>	300 N V	DDRESS, CITY, STATE, ZIP COD VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
	be held with the apprelocation plan Do of care where reside administering the reattending physician discharge order. Te acceptableDischa When the resident versident's family/Reather esident home a refuses to give a discharge order. At the resident or the replaced in the health completed 4. The need to contact the the resident's safety Transfer: 1. Obtain the attending physic emergency, contact the Alternate physic the Medical Director available, contact all ambulance for reason to the reside applicable send the Transfer/Discharge resident and/or represponsible for care health record. 7. Co for make 2 copies or record necessary for Physician's Orders, x-ray, Immunization work, etc) 8. Send of portions of health record.	rge Against Medical Advice 1. wishes to go home or the esponsible Party wishes to take and the attending physician scharge order a 'Discharge dvice' form must be signed by esident's representative and record. 2. No transfer form facility should determine the appropriate State agencies if is a concernEmergency physician order for transfer. If cian is not available in an the alternate physician. 2. If ian is not available, contact or. 3. If the Medical Director is et the Director of Nursing5. transfer. 6. Explain transfer and int and/or representative, if					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PJT11

Facility ID: 000521

If continuation sheet Page 32 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		155582	B. WI	NG		01/08/	2025	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP COD			
WATERS	OF WAKARUSA S	KILLED NURSING FACILITY, THI	Ξ		RUSA, IN 46573			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
F 0677 SS=D Bldg. 00	indicate the facility preparation or orien a safe discharge. This citation relates 3.1-12(a)(3) 3.1-12(a)(18) 3.1-12(a)(20) 3.1-12(a)(21) 3.1-12(a)(22) 3.1-12(a)(23) 483.24(a)(2) ADL Care Provide Based on observation review, the facility fresidents had receiv according to their two of 3 residents review and Resident X) Findings include: 1. During an interview and Resident R indicated the floor and she had weeks. The last time had also been 2-3 windicated her showed Wednesdays and Sa	mentation in the record to provided appropriate tation to Resident E to ensure to Complaint IN00448438. d for Dependent Residents on, interview and record failed to ensure dependent ed bathing opportunities vice a week preferences for 2 wed for bathing. (Resident R ew, on 1/6/25 at 10:00 A.M., d there was only one aide on d not received a shower in 2-3 e her hair had been shampooed reeks ago. The resident ters had been scheduled for sturdays. This past Saturday, ed to the resident she was	F 06	577	It is the intent of this facility to ensure dependent residents receive a bathing opportunity according to their twice a weel preference. All residents in the facility rece a shower per preference. Residents were interviewed fo shower preferences and care updated with preferences on endated with preferences on endated with preferences on the shower schedule was updated appropriate. DON/Designee completed and for shower preferences on or before 1/27/25 and care plans	r plan d as audit	01/28/2025	
	during lunch time, s	her shower, but it had been so the resident requested to er lunch. The aide never			were updated and shower schedule updated. The DON/Designee in-service	d the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 33 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155582	B. W	ING		01/08/	/2025
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			VASHINGTON ST		
\\\\ATEDG	S OF WAKABUSA 9	SKILLED NURSING FACILITY, THE	=		RUSA, IN 46573		
WATERS	OI WANANUOA	DIVIDED NOROLING LACILITY, THE	-	WANA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	returned to provide	her a shower.			nursing staff on or before 1/27		
					on the Shower Policy to ensur	e	
		A.M., a review of the clinical			showers are being offered on		
		R was conducted. The			shower days and shower shee	ets	
		s included, but were not			are filled out in their entirety.		
		vascular accident (CVA), heart			Additionally, any staff that fails	s to	
	failure, colostomy s	status and anxiety.			comply with the point of this		
					in-service will be further educa		
	-	sion Evaluation, dated 7/5/24,			and/or disciplined as indicated		
	indicated the reside	ent preferred a shower.			DON/Designee will complete a	an	
		D			audit tool labeled "Resident	_	
		imum Data Set (MDS)			Shower Audit Tool" on 20 rand		
		0/6/24, indicated the resident's			residents weekly x 4 weeks, th		
		et, had no rejection of care			10 random residents weekly x		
	-	ired partial/moderate assist			weeks, then 5 random residen		
	with showering/bat	hing.			monthly x 4 months for showe		
	A CO DI 1 A 1	10/16/24 : 1: 4 1.1 : 1 4			proved per residents' preferen	ice.	
		10/16/24, indicated the resident			If the facility is within 95%		
	_	with ADLs (Activities of Daily			compliance at the end of the 6		
		entions included, but were not			months; then monitoring can be		
	-	ge the resident to complete as			stopped. Results of the monito	-	
	-	extensive assist of one person			will be reviewed at the monthly	•	
		s and bathe resident per the			QAPI meeting. Any concerns		
		te twice a week. There was no			have been addressed. Howev		
		g the resident had a pattern of			any patterns will be identified.	-	
	refusal of care.				needed Action Plan will be wri	ιιen	
	A forms titled "Ches	yyan Damant II in diaatad on the			by the QAPI committee. Any		
		wer Report," indicated on the			written Action Plan will be	_	
	in December 2024	resident was offered a shower			monitored by the Administrato	r	
		sday- indicated resident refused			weekly until resolved.		
	a shower.	saay- muicateu resident letused					
		y-indicated the resident					
		with shampoo, lotion and nail					
		with shampoo, fonon and han					
	care.						
	- 12/11/24 a Wednesday-indicated the resident						
	refused a shower.						
	- 12/14/24 a Saturday- indicated the resident						
	refused a shower.	esday-indicated the resident					
	- 12/10/24 a weallt	ouay-muicateu me lesidem	1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 34 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155582	B. W	ING		01/08/	/2025
NAME OF A	DOLUBED OF CURPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R		300 N V	VASHINGTON ST		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, TH	IE ——	WAKAR	RUSA, IN 46573		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		a shower on 12/17/24, however					
	there was no shower sheet for that day.						
	- 12/21/24 a Saturday-indicated the resident refused a shower.						
		y-indicated the resident					
	received a shower a						
		lay-indicated the resident					
	refused a shower.	-					
		er sheet for 1/4/25 provided.					
		cumentation Survey Report for					
		d January 2025", was provided					
		Nursing. The form indicated the					
		ver on the following days:					
		nd none recorded for January					
		ower report indicated no					
	shampoo had been	completed for the resident.					
	2. On 1/5/25 at 10:4	43 A.M., Resident X's son					
	indicated he had co	ncerns about the lack of					
	showers provided b	by the facility staff.					
	During an observat	ion, on 1/5/25 at 10:53 A.M.,					
		served in bed, she was alert to					
		e to recall what day it was. The					
	room had an odor o	of stool. CNA 29 knocked on					
	the resident's door a	and entered with supplies to					
	change the resident	. The CNA was observed to					
	assist the resident a	and change her brief without					
	concerns noted.						
	On 1/7/25 at 2:53 P	P.M., a review of the clinical					
		X was conducted. The record					
		ent was admitted on 11/18/24.					
		noses included, but were not					
		a, osteoporosis, difficulty					
	walking and weakn						
	The Admission Min	nimum Data Set (MDS)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 35 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (00) COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155582	A. Bl B. W		00	01/08	
		100002	Б. W			01/00/	
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF WAKARUSA S	SKILLED NURSING FACILITY, T	HE		RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 1/22/24, indicated the	+	TAG	DEFICIENC!)		DATE
	· ·	was moderately impaired and					
	-	derate assistance of 1 person's					
	with a shower.	•					
	An Activity Admis	sion Evaluation, dated					
	-	the resident preferred a					
	shower.	-					
	The Care Plan for p	preferences, dated 11/20/24,					
		ent a shower twice a week but					
	•	dicate what days the showers					
		ADL care plan was not					
	received.						
		wer Report" indicated on the					
	-	resident was offered a shower					
	in December 1014	_					
		y indicated the resident had a want her hair washed.					
		esday indicated the resident					
		er 3 times so staff provided a					
	complete bed bath.						
		lay indicated the resident had a					
	shower and shampo						
	shower and shampo	ay indicated the resident had a					
	-	ver reports provided for					
	January 2025.						
	A form titled. "Doc	cumentation Survey Report for					
		ecember 2024 and January					
	· ·	ed by the Director of Nursing.					
		the resident had a shower on					
		5. The form indicated she					
		on 11/27/24, 12/10/24 and					
	12/22/24.						
	A form titled "Suns	shine Pod Showers", indicated					
	Resident X should	have received her showers on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 36 of 46

STATEMENT OF DEFICIENCIES		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155582	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION CONST	(X3) DATE SURVEY COMPLETED 01/08/2025	
	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA SKILLED NURSING FACILITY, THE SUMMARY STATEMENT OF DEFICIENCIE STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 0693 SS=D Bldg. 00	Consultant provided for Bathing", dated policy was the one of The policy indicate promote circulation. On 1/7/25 at 11:02. Consultant indicate policy related to she opportunities. This citation relates. This citation relates. 3.1-38(a)(3) 3.1-38(b)(2) 3.1-38(b)(3) 483.25(g)(4)(5) Tube Feeding Mg Based on observation review, the facility were documented a 2 of 3 residents review. (Resident E and Reference in 1/5/25 at 2:00 P. the facility on 11/23 following surgical in pancreatitis. The result were not limited perforation of the experience in the perforation of the experience in the perforation of the experience in the policy was the one of the perforation of the experience in the policy was the policy in the perforation of the experience in the policy in the perforation of the experience in the policy in the perforation of the experience in the policy in the policy in the policy in the perforation of the experience in the policy in the perforation of the experience in the policy in the perforation of the experience in the policy in the perforation in the perforation of the experience in the policy in the perforation of the experience in the perforation i	a.M., the Regional Nurse of a policy titled, "Guidelines 9/21/23, and indicated the currently used by the facility. It is a cleanse the skin and to" A.M., the Regional Nurse of the facility had no ADL owers or bathing to Complaint IN00450476.	F 0693	It in the intent of this facility to ensure tube feedings are documented as ordered by the physician. Resident E returned to the facili on 1/24/25 and no longer requir tube feedings per physician orders. On 1/6/25 resident S's piston syringe and water bottle discarded, and a new piston syringe and water bottle discarded, and a new piston syringe and water bottle dated a put in place by the DON/Designee. The DON/Designee assessed Resident S and no negative outcome related to the alleged	es	

FORM CMS-2567(02-99) Previous Versions Obsolete

disease with esophagitis, fistula of the stomach

Event ID:

0PJT11

Facility ID: 000521

deficient practice on 1/6/25.

If continuation sheet

Page 37 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/08/2025 155582 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and duodenum, and gastrostomy placement. The All residents requiring tube resident had a gastrostomy/jejunostomy tube (a feedings have the potential to be GJ tube - combination of a tube placed in the affected by the alleged deficient stomach and a tube placed in the jejunum that is practice. DON/ Designee secured with a balloon or plastic bumper in the completed an audit of physician stomach and a plastic disc around the outside of orders for all residents with tube feedings. All care plans were the body.) The resident was admitted with physician orders for enteral tube feedings and reviewed and revised as necessary nothing by mouth (NPO) except diet soda and on 1/13/25. medications. The DON/Designee in-serviced the Nursing staff on guidelines for The Admission Minimum Data Set (MDS) enteral tube feeding and assessment, dated 11/30/24, indicated the resident documentation on or before was cognitively intact, was dependent on staff for 1/27/25. Additionally, any staff feedings, required enteral feedings and received that fails to comply with the point 51% or more of his total calories via a J-tube. of the in-service will be further educated and/or disciplined as A Care Plan, dated 11/25/24, indicated the resident indicated. had the inability to tolerate oral intake and had a DON/Designee will complete an jejunostomy in place for nutrition. The titled "Enteral Feed Audit Tool" five interventions included, but were not limited to, times a week for 4 weeks for Give J-tube feeding as ordered, monitor J-tube site documentation of tube feeding daily for signs of infection and report any administration on EMAR and problems to the physician. dating of piston syringe and water bottle, then 3 times a week x 4 A Registered Dietician Note, dated 11/25/24 at weeks, then once a week x 4 4:41 P.M., indicated Resident E was admitted from months. If the facility is within the hospital and a J-tube had been placed for 95% compliance at the end of the feedings. The note indicated "...Diet: NPO except 6 months; then monitoring can be ice chips and diet soda. Enteral Feed: current stopped. Results of the monitoring order is 4a-12p feed with no rate indicated, 60 ml will be reviewed at the monthly flush q [every] shift. Review: Resident requiring QAPI meeting. Any concerns will enteral feeds via PEGJ tube for pancreatic rest have been addressed. However, post pancreatitis. J port (yellow) must be used for any patterns will be identified. Any feeds. Noted per hospital notes resident can have needed Action Plan will be written ice chips and diet coke by mouth. Resident is by the QAPI committee. Any mobile and would like some daytime off feed to written Action Plan will be move around facility etc. Resident will transition monitored by the Administrator to [name of enteral feed] 1.5 per facility weekly until resolved. availability...[name of enteral feed] 1.5 total

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED		
		155582	B. WING			01/08/	01/08/2025	
			C7	DEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			VASHINGTON ST			
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE					RUSA, IN 46573			
WATERC	OI WARAROSA C	SKIELED NORSING I ACIEIT I, ITI	<u> </u>					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE	
	-	day provides: 2362 kcals/106 g						
	•	e water. Tube flushed for						
		after feeds. Meets 100% of						
		nd protein needs. Resident to						
	take water orally to	meet fluids needs"						
	·	Report, indicated the						
	following:							
		der every shift for supplemental						
		end midnight 105ml/hr						
]. Flush before and after feed w						
		er" Start date was 11/27/24.						
	There was no end d	ate documented						
	" Entaral Food Ora	der every shift for supplemental						
		nal feed] 105 ml/hr 12pm-2pm						
	_	opm to 7am 105 ml/hr. total						
		ish before and after feed w						
		er" Start date was 12/5/24.						
	[with] boilin of wate	51 Start date was 12/3/24.						
	The Medication Ad	ministration Record (MAR) for						
		licated "[Name of enteral						
		400 off at midnight. Flush with						
	~ -	ter each feeding" Start date						
		late 11/27/24. Nurses initialed						
		ing and night shift; however,						
	-	nentation on the MAR or						
	Treatment Adminis	tration Record (TAR) which						
	indicated the entera	l feeding was started at 4:00						
	A.M., stopped at mi	idnight, nor the amount the						
	resident received du	uring the eternal feeding.						
	There were initials	on 11/27/2, by the day nurse;						
	however, starting 1	1/28/24, there were no other						
		the November MAR indicating						
		eived his enteral feedings.						
	The December MA							
	documentation relat	ted to the enteral feedings.						
		December 2024 MAR						
	indicated "NPO [no	othing by mouth] except meds,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 39 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155582	B. WING			01/08/2025	
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			_		VASHINGTON ST		
WATERS	OF WANARUSA	SKILLED NURSING FACILITY, TH	_	WAKAK	RUSA, IN 46573		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRI			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	ice chips or diet soo	da only by mouth" Nurses					
	were documenting	the resident was NPO on the					
	November and Dec	ember MAR with start date of					
	11/23/24 and end d	ate 12/24/24.					
	During an interview	v, on 1/8/25 at 11:09 A.M., the					
	Director of Nursing	g (DON) indicated she had not					
	found other docume	entation of the enteral feeding					
	for Resident E and	indicated it would have been					
	documented on the	MAR/TAR.					
		47 A.M., a review of the clinical					
	record for Resident	S was conducted. The					
	1	s, included but were not					
	limited to, Alzheim	er's Disease, diabetes and					
	dysphagia (difficult	ty swallowing).					
		um Data Set (MDS)					
		0/25/24, indicated the					
	_	was severely impaired,					
	_	noderate assistance with eating					
		or more of total calories via					
		ny tube is an opening in the					
	stomach to insert a	tube for nutritional support)					
		6/13/24, indicated the resident					
	_	dysphasia and had a G-tube in					
	1 ^	The interventions included,					
		d to, Give G-tube feeding as					
		-tube site daily for signs of					
	infection and flush	G-tube as ordered.					
	1 -	acluded the following:					
		feed, five times a day, for					
		1.5, administer 237ml					
	(milliliters).						
		and container for G-Tube to be					
		shift. Please make sure you					
	date and initial ever	ry night shift.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 40 of 46

PRINTED: 02/20/2025

	T OF HEALTH AND HU R MEDICARE & MEDIC						ORM APPROVED MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2025	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	HE	300 N V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RUSA, IN 46573		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	December 2024, in five times a day for [calores] give 237 centimeter] before indicated the times 8:00 A.M., noon, 4 record indicated the enteral feeding on -12/4/24 at 12:00 A-12/4/24 at 12:00 A-12/4/24 at 12:00 A-12/13/24 at 12:00 A-12/13/24 at 8:00 F-12/14/24 at 8:00 F-12/14/24 at 8:00 F-12/14/24 at 8:00 F-12/20/24 at 12:00 A-12/20/24 at 12:00 A-12/20/24 at 8:00 F-12/20/24 at 8:00 F-12/20/24 at 8:00 F-12/23/24 at 4:00 F-12/23/24 at 4:00 F-12/23/24 at 8:00 F-12/24/24 at 8:00 F-12/25/24 at 8:00 F-12/25/24 at 4:00 F-12/25/24 at 4:00 F-12/25/24 at 12:00 During an observat 11:25 A.M., the res for administrating to	M. A.M. A.M. P.M. P.M. P.M. P.M. P.M. P.					

FORM CMS-2567(02-99) Previous Versions Obsolete

piston's package covering and water bottle should have been dated. The night shift was responsible for throwing out both the piston syringe and bottle, replacing them with new devices and dating the equipment. LPN 21 indicated Resident

S did not refuse any tube feedings.

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 41 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/08/2025					
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST WAKARUSA, IN 46573				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0732	DON indicated the documented each ti administered. The besupplement record signed and/or not accord on 1/6/25 at 2:57 P. Consultant provided for Enteral Feeding indicated the policy by the facility. The To provide guidanc staff in hanging and administering T. Nutrition-to residen administration The changed every 24 h indicated the policy to enteral feeding. The where or when to documentation policy of 1/6825 at 10:28 provided a policy ti Documentation", da policy was the one of The policy indicated not write it down, y. This citation relates 3.1-44(a)(2)	A.M., the Administrator tled, "Guidelines for Nursing ated 5/17/23 and indicated the currently used by the facility. d "9. Remember "If you did					
SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Star Based on observation	ffing Information	F 0732	It is the intent of this facility to	01/28/2025		
		failed to ensure nurse staffing	1.0/32	ensure nurse staffing informat			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

Page 42 of 46

02/20/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/08/2025 155582 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE information was posted for the residents and their is posted for residents and their families to review. This had the ability to affect all families to review. of the residents and their family members. There were not residents affected by this alleged cited practice. Finding includes: All residents have the potential to be affected by the cited practice, On 1/2/25 at 3:39 P.M., a posting of a form titled, therefore, this plan of correction "Nursing Staff Directly Responsible For Resident applies to all residents that reside Care", dated 11/18/24, was observed near the in the facility. entrance to the facility behind a glass case. The The Regional Nurse form indicated how many Registered Nurses (RN), Consultant/Designee completed Licensed Practical Nurses (LPN), and Certified education with facility scheduler, Nurse Aides (CNA) were working in a 24 hour Director of Nursing and Nursing period. The bottom of the form indicated, "...Daily Managers on posting nursing posting of this information is required for nursing staffing information daily on participation in Medicare and Medicaid...." 1/24/25. Additionally, any employee who fails to comply with On 1/2/25 at 4:46 P.M., the Director of Nursing the points of the in-service may be (DON) observed the nurse staff posting and further educated and/or indicated this was the only place the form was progressively disciplined as displayed in the facility. The DON confirmed the indicated. date on the form was 11/18/24 and indicated it was The Administrator/designee will the scheduler's job to post the nurse staffing complete daily staffing posting daily. audits 5x's a week x 4 weeks, then 3 times a week x 4 weeks, During an interview, on 1/2/25 at 5:09 P.M., the then once a week x 4 weeks, then Administrator indicated it was the DON and once a month x 3 months for Assistant Director of Nursing's responsibility to current daily staffing posted. If post the daily nurse staffing since the facility the facility is within 95% currently did not have a scheduler. compliance at the end of the 6 months; then monitoring can be On 1/2/25 at 5:12 P.M., the DON provided a policy stopped. Results of the monitoring titled, "Guidelines for BIPA Staffing Posting will be reviewed at the monthly Requirement", dated 7/24/23 and indicated the QAPI meeting. Any concerns will policy was the one currently used by the facility. have been addressed. However, The policy indicated "...It is the policy of the any patterns will be identified. Any

FORM CMS-2567(02-99) Previous Versions Obsolete

facility, in cooperation with Medicare/Medicaid

Services, (CMS), to comply with the requirement

of daily posting of nursing staff in the facility...."

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet

needed Action Plan will be written

by the QAPI committee. Any

written Action Plan will be monitored by the Administrator

Page 43 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155582 B. WING 01/08/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 N WASHINGTON ST WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE WAKARUSA, IN 46573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE weekly until resolved. F 0812 483.60(i)(1)(2) SS=F Bldg. 00 Procurement, Store/Prepare/Serve-Sanitary Based on observation, interview and record 01/28/2025 F 0812 It is the intent of this facility to review, the facility failed to ensure hot food and ensure hot food and cold liquids cold liquids were served and maintained in a are served and maintained in a sanitary and safe manner related to staff touching sanitary and safe manner. food and other items both with the same gloved The DON/Designee assessed hands during meal service and not keeping room residents on 1/6/25 and no tray meal cart food at the proper serving negative outcome related to the temperature during two random food service alleged deficient practice. observations. (Main Kitchen and ICF/Maple Unit) All residents have the potential to This had the potential to affect all residents who be affected by the cited practice, received food and drinks from the kitchen. therefore, this plan of correction applies to all residents that reside Findings include: in the facility. The Adm/Designee in-serviced the 1. During dinner service on 1/3/25 at 5:30 P.M. dietary on the following. 5:33 P.M., the following was observed from the 1. Glove and Hand Washing entrance to kitchen: The Dietary Manager (DM) Procedures. and Dietary Aide 28 were in the kitchen wearing 1. Cooking Food Temperatures blue gloves which covered their hands. The DM and Holding Times took one gloved hand, grabbed a plate and 1. Handling Food in a Sanitary removed a piece of fish from the steamer pan with and Safe Manner her other gloved hand. Then, with the same hand, Additionally, any staff member scooped up a serving of carrots with a ladle and that fails to comply with the points continued down the steamer with the same gloved of this in-service will be further hands, touching each ladle. The DM placed the educated and/or disciplined as plate on a tray and took it to an open counter, indicated. which she touched with her gloved hand, to be The Dietary Manager or Designee picked up by a facility staff member who served will audit 10 random meal services the tray to a resident. Dietary Aide #28 followed weekly to ensure dietary staff are behind the DM and was observed taking his blue handling food in a sanitary and gloved hand, grabbing a plate and removing a safe manner and using appropriate piece of fish from the steam pan with his gloved utensils to serve food and food hand, then placing the fish on a plate. He then temperatures are maintained added the carrots and on down the steamer during serving and while serving on touching the ladle handles with the same gloved hallways, then 5 random meals

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155582	B. WING 01/08/2025			2025	
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VASHINGTON ST		
WATERS	S OF WAKARLISA S	SKILLED NURSING FACILITY, THE	.		RUSA, IN 46573		
	, or written o	DATE DISTORTION AGENT, THE		**/ \ \/~\ \			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	he plate on a tray to be			services weekly x 4 weeks, the	en	
		dent. As Dietary Aide 28			one meal service weekly x 4		
		m table, the DM repeated the			months. If the facility is within		
	-	he same gloved hands, as did			95% compliance at the end of		
	Dietary Aide 28 aga	ain.			6 months; then monitoring can		
	On 1/2/25 -4 5 24 B	M the DM in direct del 1 1 1			stopped. Results of the monito	-	
		.M., the DM indicated she had			will be reviewed at the monthly		
		s in the pan of fish and should to remove the fish from the			QAPI meeting. Any concerns the second However		
	pan instead of her g				have been addressed. However		
	pan mstead of her g	novea manas.			any patterns will be identified. needed Action Plan will be wri	-	
	On 1/7/25 at 10.38	A.M., the Administrator			by the QAPI committee. Any	u c II	
		ed, "Glove and Hand Washing			written Action Plan will be		
	-	2017 and indicated the policy			monitored by the Administrato	r	
		ly used by the facility. The			weekly until resolved.	'	
		7. Gloves are changed any time			weekly until resolved.		
		d be required. This includes					
	_	tchen for a break, or to go to					
	_	the building; after handling					
		us raw food; or if the gloves					
		ed by touching the face, hair,					
		food contact surface, such as					
	door handles and ed	quipment"					
	2. On 1/5/25 at 1:02	2 P.M., the meal cart arrived to					
	_	with approximately 5 trays.					
		er had accompanied the cart to					
	•	taken from the cart and the					
		ares of the food, were recorded:					
	Italian Sausage - 11	_					
	Pasta - 149 degrees						
	Fruit punch drink -	_					
	After the Dietary M						
	_	nusage was tasted and was not					
	palatable for consur	mption, as it tasted uncooked.					
	Duning on intermi	on 1/5/25 at 1:07 D.M. the					
		y, on 1/5/25 at 1:07 P.M., the dicated the sausage had not					
		r temperature and the punch					
		should be served cold. The					
	was 100 wariii, as it	Should be served cold. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0PJT11

Facility ID: 000521

If continuation sheet Page 45 of 46

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

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155582		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2025			
NAME OF PROVIDER OR SUPPLIER WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 N WASHINGTON ST E WAKARUSA, IN 46573					
WATERS OF WARAROSA SKILLED NORSING FACILITY, THE			-	WAIXAI				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		dicated the kitchen only had						
		nd there were more residents						
		ms than the facility had plate						
		ne facility had 5 resident units						
	in the facility.							
	provided a form titl Cooking Food Tem dated 2017, and ind currently used by th Pork or Beef minim degrees. "8. Meal- may be periodically service for palatable temperatures of hot point of service are or greater to promo- resident"	a.M., the Administrator ed, "Resource: Minimum peratures and Holding Times", dicated the policy was the one ne facility. The policy indicated num temperature was 145 s that are served on room trays or checked at the point of ne food temperatures. Food foods on room trays at the preferred to be a 120 degrees te palatability for the						
		to Complaints IN00450476, 449158 and IN00448896.						
	3.1-21(a)(2)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0PJT11 Facility ID: 000521 If continuation sheet Page 46 of 46