STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155251	B. WING		10/29/2024		
			OWNER	ADDRESS CITY STATE TIP COP			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD			
WATER		LLED NUIDSING FACILITY THE		V 37TH AVE			
WATERS	OF HUDART SKI	LLED NURSING FACILITY, THE	пова	RT, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
		the Investigation of Complaints	F 0000	This plan of correction shall s	erve		
	IN00440342 and II	N00443034.		as this facilities' credible alleg	ation		
				of compliance Preparation,			
	Complaint IN0044	0342 - Federal/State deficiencies		submission, and implementat	ion		
	related to the alleg	ations are cited at F686, F698,		of the plan of corrections doe	s not		
	and F842.			constitute an admission of or			
				agreement with the facts and			
		3034 - Federal/State deficiencies		conclusions set forth in this s	-		
		ations are cited at F686, F693,		report Our plan of correction	s		
	F842, and F880.			prepared and executed as a			
				means to continuously improv	/e		
	Survey dates: October 28 & 29, 2024			the quality of care and			
				to comply with all applicable s	state		
	Facility number: 0			and federal regulatory			
	Provider number:			requirements			
	AIM number: 100	289680		The facility respectfully			
				requests paper compliance T	hank		
	Census Bed Type:			you for your consideration,			
	SNF/NF: 47			Respectfully,			
	Total: 47						
				Kevin Mehay HFA			
	Census Payor Type	e:		Waters of Hobart			
	Medicare: 8			317.525.3537			
	Medicaid: 33						
	Other: 6						
	Total: 47						
	Th						
		reflect State Findings cited in					
	accordance with 4	10 IAC 16.2-3.1.					
	0 14	1 4 1 11/4/24					
	Quality review cor	mpleted on 11/4/24.					
F 0686	192 25/h\/1\/;\/;;\						
SS=D	483.25(b)(1)(i)(ii)	o Prevent/Heal Pressure					
Bldg. 00	Ulcer	O FIEVERWITEAL FIESSUIE					
Diag. 00	Olcei		F 0686	Waters of Hobart	10/31/2024		
	Based on observati	ion, record review, and	L 0090	Waters of Honard	10/31/2024		
	Dased on observati	ion, record review, and					
LADODATO	OV DIDECTORIC OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	ICNATURE	TITLE	(VA) DATE		
LADUKATUI	AT DIRECTOR'S OR PRO	OVIDEN SUFFLIER REPRESENTATIVE'S S.	IONATURE	HILE	(X6) DATE		
Kevin Meh	ay		Executiv	Executive Director			

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 disclo

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 54NX11 Facility ID: 000154 If continuation sheet Page 1 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155251	B. WI	NG		10/29/	/2024
				CERTE	A DDDDGG GITTY GT ATE TID GOD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		LLED NUIDOING EAGULTY THE			/ 37TH AVE		
WATERS	OF HOBART SKI	LLED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interview, the facil	ity failed to ensure a resident			F686		
	with a pressure ulc	er received the necessary			Preparation and/or execution	of	
	treatment and servi	ices to promote healing, related			this plan of correction in gener	ral,	
	to treatments not co	ompleted as ordered for 1 of 3			or this corrective action does i	not	
	residents reviewed	for pressure ulcers. (Resident			constitute an admission of		
	F)				agreement by this facility of th	e	
					facts alleged or conclusions s	et	
	Finding includes:				forth in this statement of		
					deficiencies. The plan of corre	ction	
	During an observat	tion on 10/28/24 at 9:34 a.m.,			and specific corrective actions	are	
	CNA 1 and QMA	2 were providing morning care			prepared and/or executed in		
	to Resident F. The	resident was turned to the right			compliance with State and Fe	deral	
	side and an uncove	ered pressure area was			Laws. Facility's date of alleged	d	
	observed to the rig	ht side of the sacral area. The			compliance is 10-31-24. Facili	ty is	
	area had depth and	was approximately 3			respectfully requesting paper		
	centimeters (cm) b	y 2 cm in size. There was no			compliance for all deficiencies	in	
	observed drainage.	CNA 1 indicated she had not			this POC.		
	received the inforn	nation in morning report at 6:30					
		ng was off. She indicated the			F686 Treatment/services to		
		orted they last completed			prevent/heal pressure ulcers	;	
		m. CNA 1 left the room to			It is the policy of this facility to		
	report the dressing	was not in place to the nurse.			ensure residents with pressure	е	
					ulcers receive the necessary		
		tion on 10/28/24 at 10 a.m., LPN			treatment and services to pror	note	
		. He indicated he had not been			healing.		
		ght nurse during the shift report			What corrective action(s) wil	ıI	
		as off the pressure area. The			be accomplished for those		
		ashed with wound wash and			residents found to have been	n	
		loves were changed and then			affected by the deficient		
		d inside the wound wound and			practice:		
		n calcium alginate and a border			The DON/Designee assessed	J	
		dated the dressing. Zinc oxide			resident F and no negative		
	was not applied du	ring the treatment.			outcome related to the alleged	t	
					cited practice.		
		l was reviewed on 10/29/24 at			How the facility will identify		
		noses included, but were not			other residents having the		
	limited to, stroke a	nd diabetes mellitus.			potential to be affected by the	ı e	
					same deficient practice and		
I	A Ouarterly Minin	num Data Set assessment, dated	1		what corrective action will be	e	İ

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

9/5/24, indicated the cognition status was not

Event ID:

54NX11

Facility ID: 000154

taken.

If continuation sheet

Page 2 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155251	B. W	ING		10/29	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\/\\TEDG	S OE HOBART SKII	LLED NURSING FACILITY, THE			RT, IN 46342		
VVATERS	OF HODAK I SKIL	LLD NUNSING FACILITY, THE		HODAR	\		
(X4) ID	SUMMARY	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	<u> </u>	TAG	DEFICIENCY)		DATE
	•	ne resident unable to answer,			The DON/Designee completed	d an	
		viors, dependent for all			audit of Wound Nurse		
	activities of daily living, always incontinent of				Practitioners notes and verifie	d	
		and had one stage three (full			correct treatment in place for		
	thickness skin loss) pressure area.				residents with pressure ulcers	on	
		10/00/04	1		10-31-24.		1
	A Care Plan, dated 10/20/24, indicated a pressure				What measures will be put in	nto	
	~	outtocks. The interventions	1		place or what systemic		1
		nent would be completed as			changes will be made to		
	ordered.				ensure that the deficient		
	. c1' /W. 1.D.	N 10/0/04 0.00			practice does not recur.		
	A Skin/Wound Progress Note, dated 9/8/24 at 8:32				The DON/Designee in-service	d the	
	-	age three pressure area had			nursing staff on completing		
	been found on the r	-			treatments as ordered on DAT		
		2.5 cm by 1.1 cm with a depth of			The DON/Designee in-service		
	0.1 cm.				wound nurse on reviewing the		
	A Disserial and Confer				wound nurse practitioners not		
		r, dated 9/9/24, indicated the			and updating treatment orders	s as	
		eansed, collagen was to be			needed on 10-31-24.	_	
	evening shift and as	a was to be covered, daily on			Additionally, any staff member		
	evening sinit and as	s needed.			that fails to comply with the po of these in-services will be fur		
	A Dhygiaian's Order	r, dated 10/3/24, indicated a				uiei	
	•	he right buttock wound. The			educated and/or disciplined.		
		nsed, patted dry, and medical			How the corrective action(s)		
		be placed into the wound.			will be monitored to ensure t		
	-	as to be applied and the area			deficient practice will not	C	
	_	n dressing every evening and			recur, i.e., what quality		
		er was discontinued on			assurance programs will be	nut	
	10/20/24.	al discontinued on			into place.	put	
	- 5 5 1.				The DON/Designee will audit		
	A Wound Nurse Pr	actitioner Progress Note,			wound nurse practitioners not	es	
		4, the wound was improving			weekly and verify correct		
		ons. There was 30% of slough			treatment order in place x 6		
	•	I. The peri-wound was intact,			months.		
		ted. A treatment of collagen in			The DON/Designee will audit		
		by calcium alginate and then			treatments on residents with		
		be completed daily.			pressure ulcer for correct		
					treatment in place five times a	1	
	The Wound Nurse I	Practitioner's treatment order			week v 1 weeks then 3 times		1

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet Page 3 of 15

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/29/2024 155251 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2901 W 37TH AVE WATERS OF HOBART SKILLED NURSING FACILITY, THE **HOBART, IN 46342** (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 had not been transcribed on 10/4/24 and the week x 4 weeks, then 3 times a treatment of the medical grade honey to the month x 4 months. wound continued. If the facility is within 95% compliance at the end of the 6 A Physician's Order, dated 10/12/24, indicated zinc months; then monitoring can be oxide paste was to be applied to the peri-wound stopped. Results of the monitoring daily with the pressure wound treatment. will be reviewed at the monthly QAPI meeting. Any concerns will A Physician's Order, dated 10/20/24, indicated the have been addressed. However, right buttock pressure area was to be cleansed, any patterns will be identified. Any patted dry, collagen was to be applied in the needed Action Plan will be written wound then covered with calcium alginate and a by the QAPI committee. Any border gauze daily on evening shift and as written Action Plan will be needed. monitored by the Administrator weekly until resolved. A Wound Nurse Practitioner Progress Note, dated 10/24/24, indicated the wound was stable with Date Of Completion: 10-31-2024 10% slough. The peri-wound remained fragile, macerated, and now excoriated. There was a moderate amount of serosanguinal drainage. The daily treatment orders were changed to cleanse the wound, apply collagen in the wound, cover with calcium alginate and a border gauze. Zinc oxide was to be used on the peri-wound daily. During an interview on 10/29/24 at 2:27 p.m., the Corporate Regional RN indicated the Wound Nurse at the facility documented the information from the Wound Nurse Practitioner. She acknowledged the treatment orders were different than the Nurse Practitioner's orders. During an interview on 10/29/24 at 2:51 p.m., the Corporate Regional RN indicated there was no documentation that indicated why the medical grade honey had been ordered for the right buttock wound and acknowledged the treatment had not been changed when ordered by the Wound Nurse Practitioner on 10/4/24. The treatment order had not been changed until

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet

Page 4 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155251	B. WI	NG		10/29	/2024
			<u> </u>	STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			/ 37TH AVE		
WATERS	OF HOBART SKII	LED NURSING FACILITY, THE			RT, IN 46342		
	. C. HODART ORIE	TEED MORGING I MOIEIT I, ITIE		1100,41	,		
(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
	10/20/24.						
	TTI 6 :1: / 1 : /	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	-	yound policy, dated 10/9/23,					
	and received from the Minimum Data Nurse as current, indicated, the Physician/Nurse Practitioner was to be notified for orders for						
	treatment for the wound and the orders were to be						
	entered into the medical record and treatment and medication record as they are received. The orders						
	were to be documented in the progress notes.						
	Upon receipt of the order, immediate transcription						
		e Medication/Treatment					
Administration Record was to be completed and the treatment was to be initiated.		_					
	the treatment was to	o de initiated.					
	This citation relates	to Complaints IN00440342					
	and IN00443034.						
	3.1-40(a)						
F 0693	483.25(g)(4)(5)						
SS=D		mt/Restore Eating Skills					
Bldg. 00	rabe recuiring Migi	The tostore Lating Okins					
J. 33	Based on record rev	view and interview, the facility	F 06	593	Waters of Hobart		10/31/2024
		ropriate treatment and	•	,,,,	F693		10/31/2021
		ded to residents with feeding			Please accept the following as	s the	
	_	ysician's orders not followed			facility's credible allegation of		
	when checking for	proper placement of the			compliance. This plan of		
	feeding tubes, for 2	of 3 residents reviewed for			correction does not constitute	an	
	feeding tube care. (1	Residents B and E)			admission of guilt or liability by	/ the	
					facility and is submitted only ir	า	
	Findings include:				response to the regulatory		
					requirement.		
	· ·	sed record was reviewed on			F693 Tube Feeding		
	•	m. The diagnoses included, but			Mgmt/Restore Eating Skills		
	were not limited to,	stroke.			What corrective action will b	е	
					accomplished for those		
		um Data Set (MDS)			residents found to have been	า	
		/14/24, indicated a severely			affected by the deficient		
	impaired cognitive	status, a feeding tube was			practice.		

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

Event ID:

54NX11

Facility ID: 000154

If

If continuation sheet Page 5 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155251	B. W	ING		10/29	/2024
			<u> </u>	CTDEET A	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD 7 37TH AVE		
\\/\TEDC	C OE HODADT SKII	LED NUBSING EACH ITY THE					
WATERS	OF HUDART SKIL	LED NURSING FACILITY, THE		HUDAK	RT, IN 46342		
(X4) ID	SUMMARY	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	present and supplied	d 51% or more of nutrition and			Resident B no longer resides	at	
	501 cubic centimete	ers (cc) or more of fluids daily.			the facility.		
					Resident E was assessed by t	the	
	A Physician's Order, dated 6/7/24, indicated the				RNC/Designee on 010/28/202	24, no	
	feeding tube placement was to be checked for				negative outcome related		
	placement and the r	residual was to be documented			treatment and services provide	ed to	
	prior to the adminis	tration of medications, formula,			resident with feeding tubes.		
	and flushing.						
					How other residents having	the	
		6/13/24, indicated a feeding			potential to be affected by th	e	
	•	The interventions included, the			same deficient practice will b	ре	
	tube would be checked for placement and gastric				identified and what correctiv	e	
	contents/residual volume would be recorded.				action will be taken.		
					The DON/Designee completed	d an	
		ministration Records (MARs),			audit of all residents with feed	ing	
		2024, indicated the placement			tubes to ensure appropriate		
	_	was to be checked prior to the			treatments and services are		
		edications, formula, and			correctly provided, Physician		
	_	sidual was to be documented.			Orders are followed, and Care)	
	_	ck was scheduled for days,			Plans are updated.		
		. The amount of residual after					
	each check had not	been documented.			What measures will be put in	1	
					place and what systemic		
					changes will be made to		
		ord was reviewed on 10/29/24 at			ensure that the deficient		
	_	gnoses included, but were not			practice does not recur.		
	limited to, severe pr	rotein deficiency.			The DON/Designee in-service		
		3 10/15/21			nursing staff by on 10/30/2024	l on	
		S assessment, dated 9/15/24,			following.		
		rely impaired cognitive status,			1 Following a physician's		
		present and supplied 51% or			orders		
		nd 501 cubic centimeters (cc) or			2 Enteral Feeding policy		
	more of fluids daily	·-			3 Care plans for enteral fee	_	
	A Dhygiair-1- O 1	n datad 0/17/24 ind:4-141-			How the corrective action wi	II	
	1	r, dated 9/17/24, indicated the			be monitored to ensure the		
	_	be checked for placement tration of medications, formula			deficient practice will not		
	1 ^				recur, i.e what quality		
	documented.	mount of residual was to be			assurance program will be p	ut	
	documented.				into place.		

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet

Page 6 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	ETED
		155251	B. WIN	NG		10/29/	2024
			 	CTDFFT A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF HODART OKI	LED NUDOING EACH ITY, THE			37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Care Plan, dated	10/9/24, indicated a feeding			DON/designee will audit resid	ents	
	tube was present. T	he interventions indicated the			receiving enteral feeding for		
	feeding tube was to	be monitored for proper			appropriate treatment, physici	an	
	placement/gastric re	esidual.			orders, following policy and ca	re	
					plan weekly x's 4wks, then		
	The Medication Ad	ministration Records (MARs),			bi-weekly x's 8wks, and then		
		0/2024, indicated the placement			monthly x's 3 months. Any		
	_	was to be checked prior to the			identified issues will be correc		
		edications, formula, and			upon discovery and logged on		
	_	idual was to be documented.			facility QAPI tracking log. The		
	-	ck was scheduled for days,			facility QAPI team meets mon	-	
		. The amount of residual after			and any QAPI tracking logs ar		
	each check had not	been documented.			reviewed by the team to ensur	e	
					ongoing compliance for a		
	_	on 10/29/24 at 1:46 p.m., The			minimum of 6 months and unt		
		RN, indicated the amount of			facility maintains 95% complia	nce	
	residual had not bee	en documented on the MARs.			for 60 days.		
	A facility maliay for	a automal facedimose datad			Data of Commission, 40 24 24		
		r enteral feedings, dated yed from the Minimum Data Set			Date of Completion: 10-31-24		
		rrent, indicated the feeding					
		ssed every eight hours and as					
		of the tube in the stomach					
		d by observing for a change in					
	_	gth during feedings. If there is					
		aspiration of gastric contents					
	may be used for pla	-					
	or about for plu						
	This citation relates	to Complaint IN00443034.					
		•					
	3.1-44(a)(2)						
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00							
			F 06	98	Waters of Hobart		10/31/2024
		view and interview, the facility			F698		
		ing communication with a					
	-	enter, related to the facility not			F698 Dialysis		
	checking on a reside	ent's location when they did			It is the policy of this facility to		

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet Page 7 of 15

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155251	B. W	ING		10/29/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			37TH AVE		
\\/\TED	C OE HOBADT SKII	LED NURSING EACH ITY THE					
WAIERS	OF HODAK I SKIL	LED NURSING FACILITY, THE		HUBAR	T, IN 46342		
(X4) ID	SUMMARY	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		alysis appointment, for 1 of 2			ensure ongoing communicatio	n	
	residents reviewed	for dialysis. (Resident C)			between facility and dialysis		
					center and to document in the		
	Finding includes:				medical record reason resider	nt is	
					not returning from dialysis cen	iter	
		record was reviewed on			to facility.		
	10/29/24 at 8:06 a.r	n. The diagnoses included, but			What corrective action(s) wil	I	
	were not limited to,	end stage renal disease with			be accomplished for those		
	dialysis, stroke, and	dementia.			residents found to be affecte	ed	
					by the alleged deficient		
	An Modification of	the Admission Minimum Data			practice.		
	Set assessment, date	ed 6/17/24, indicated a					
	severely impaired cognitive status, dependent on				Resident C no longer resides	in	
	staff for all activitie	es of daily living, and received			the facility.		
	dialysis.						
					How will the facility identify		
		6/11/24, indicated dialysis was			other residents who have the	€	
	required. The interv	ventions included, dialysis			potential to be affected by th	е	
	would be provided	as scheduled.			same alleged deficient		
					practice?		
	•	r, indicated dialysis was to be					
		ysis center on Monday,			All resident that resides in the		
	Wednesday, and Fr	iday.			facility have the potential to be)	
					affected by the alleged cited		
	_	Note, dated 8/5/24 (Monday)			practice, therefore, this plan o		
		ned by LPN 3, indicated the			correction applies to all reside	nts	
		ot administered due to the			in the facility.		
	resident was discha	rged against medical advice.					
		ogress Note written, which			What corrective measures w	ill	
		Progress Note in the record,			the facility take, or will the		
		a.m., indicated the medications			facility alter to ensure that th	ie	
		red due to the resident was			problem will not occur?		
	discharged against i	medical advice.					
					The DON/Designee in-service		
	_	on 10/29/24 at 11:06 a.m., the			the nursing staff on document		
		of Nursing (ADON) indicated			in the EMR when a resident d	oes	
	_	ne to the dialysis Facility on			not return from dialysis or an		
		st have sent her to the			appointment any reason for no	ot	
	emergency room (ER). She had just reviewed the		l		returning on 10-31-24.		

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet Page 8 of 15

12/04/2024 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 00 COMPLETED B. WING 10/29/2024 155251 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2901 W 37TH AVE WATERS OF HOBART SKILLED NURSING FACILITY, THE **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident's hospital information and saw she was Additionally, any staff member admitted into the hospital on 8/5/24. The that fails to comply with the points information should have been documented in the of this in-service will be further record. educated and/or disciplined. During an interview on 10/29/24 at 11:11 a.m., LPN What quality assurance plans 4 indicated the resident had gone to dialysis. She will be implemented to monitor was informed the resident's Power of Attorney facility performance to ensure transferred her to the hospital from the dialysis corrections are achieved and center, though was unsure who informed her of permanent? this and when she was informed. LPN 4 indicated the resident had not been discharged against The DON/Designee will audit medical advice and she did not know why she residents return from charted that. LPN 4 indicated the dialysis center appointments/dialysis and documentation if resident did not did not always contact the facility when they sent residents to the hospital. The facility staff had not return and reason five times a contacted the dialysis center for information when week x 4 weeks, then 3 times a week x 4 weeks, then once a the resident had not returned to the facility on 8/5/24. week x 4 weeks, then once a month x 3 months. During an interview on 10/29/24 at 11:21 a.m., Dialysis Staff 1 indicated the resident's family If the facility is within 95% entered the dialysis center on 8/5/24 and informed compliance at the end of the 6 them he was taking the resident home after the months; then monitoring can be treatment. The dialysis center had not transferred stopped. Results of the monitoring the resident to the ER, they had discharged her to will be reviewed at the monthly the family. They had not notified the facility, as QAPI meeting. Any concerns will they presumed the family member would have have been addressed. However, informed them. any patterns will be identified. Any needed Action Plan will be written During an interview on 10/29/24 at 11:30 a.m., the by the QAPI committee. Any Corporate Regional RN indicated improvement written Action Plan will be was needed with documentation and she was monitored by the Administrator looking for more information. weekly until resolved. No further information had been received upon Date Of Completion: 10-31-2024 exit of the facility on 10/29/24 at 4:00 p.m. An undated hemodialysis policy and procedure, received from the Minimum Data Set (MDS) Nurse

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet

Page 9 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			î î			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00		OMPLETED	
		155251	B. W	ING		10/29/	2024	
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 2901 W 37TH AVE HOBART, IN 46342					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE	
	on 10/29/24 at 8:42	a.m., indicated the dialysis						
	center and the facili	ty will communicate						
information regarding the dialysis session.								
	This citation relates to Complaint IN00440342.							
	3.1-37(a)							
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.7 Resident Records	70(i)(1)-(5) - Identifiable Information						
3	failed to ensure a re- and accurate docum consult appointment assessment, pressure	e ulcer assessment, and ressure ulcers, for 1 of 5 for medical record	F 03	842	Waters of Hobart F842 It is the policy of this facility to ensure residents record has thorough and accurate documentation. b>What corrective action(s) w accomplished for those reside found to have been affected b deficient practice?	ill be ents	10/31/2024	
	Resident B's closed	record was reviewed on			/bResident B no longer resid	les		
	10/28/24 at 1:06 p.n	n. The diagnoses included, but			at the facility			
	were not limited to	stroke.			/p>			
					br>			
		sion Assessment, dated						
	_	pacemaker and defibrillator was			/p>			
	present.				/p>			
	Thoma	icionia andona fon mti			/p>			
		ician's orders for routine			/p>			
	pacemaker monitori	mg.			br> /p>			
	The Chest Physician	n Consult from the hospital,			/p>			
		d documentation of a			br>			
	pacemaker and/or de				How will the corrective			
	1				actions(s) be monitored to			
	The Nurse Practition	ner's Admission Progress			ensure the deficient practice			
		at 1:38 p.m., indicated the			will not recur, i.e., what quali			

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

Event ID:

54NX11 Facility ID: 000154

If continuation sheet Page 10 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155251	B. WI	NG		10/29/2024	
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
WATERO	OF HODART OKI	LED NUIDOINO EAQUITY THE			37TH AVE		
WATERS	OF HUBART SKIL	LED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	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 APPROPRIA'	COMPLETION	N
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	cardiovascular statu	s was normal cardiac rhythm			assurance program will be p	ıt	
	and no murmurs. There was no documentation				into place?		
	that indicated a pacemaker and defibrillator was				If the facility is within 95%		
	present.				compliance at the end of the	6	
	A Nurse's Progress Note, dated 6/21/24 at 10:27				months; then monitoring can		
					be stopped. Results of the		
	a.m., indicated an o	pen area in the skin had been			monitoring will be reviewed a	t	
	found on the resider	nt's left lower back. There was			the monthly QAPI meeting. A	ny	
	an abdominal binde	er on that protected a heart			concerns will have been		
	_	"placed on the upper left side			addressed. However, any		
	of his chest".				patterns will be identified. Ar	у	
					needed Action Plan will be		
	There was no further documentation in the record				written by the QAPI committe	e.	
		esident had a pacemaker,			Any written Action Plan will b	e e	
	defibrillator, or hear	rt monitor.			monitored by the Administra	tor	
					weekly until resolved.		
	_	on 10/29/24 at 9:28 a.m., the			/b>		
		RN indicated all the hospital			/p>		
		n read and there was no heart			/p>		
	_	r, or defibrillator documented in			/b>		
		rses who had documented the			Date Of Completion: 10-31-20	24	
		o longer employed by the					
	<u> </u>	Practitioner completed an					
		mission and there was no					
	_	lator, or heart monitor. The					
	nurses may have ch	arted on the wrong record.					
	1) 4 37	N 1 . 10/00/04 . 2 11					
	,	ess Note, dated 8/20/24 at 3:11					
	-	ppointment with the					
		Spine institute on 8/21/24 had to being unable to find					
		e appointment. A new					
	_						
	transportation could	be rescheduled and gurney					
	uansportation could	i oc iouiid.					
	There was no furthe	er documentation the					
	appointment had be						
	transportation had b						
	uansportation nau t	occii iounu.					
	During an interview	v on 10/29/24 at 9:29 a.m., the					

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet Page 11 of 15

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155251	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/29/2024	
	ROVIDER OR SUPPLIER	LED NURSING FACILITY, THE	2901 W	ADDRESS, CITY, STATE, ZIP COD / 37TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	Neurosurgery and Sinformed the appoint Physician's Office of the CT of the head of hematoma had reso appointment schedulit may have been an scheduled to go to a documentation probe. C) A Weekly Skin A indicated there were the Daily Skilled Nothere were no pressor. The Skin-Weight-A Progress Notes, data were no pressure ultra A Nutrition at Risk and written by Regin indicated nursing has open areas on the skindicated nursing has open areas on the sacrum Progress Notes. During an interview Corporate Regional 8/23/24 at been con RD. She had notifier recall who informed only that she was to	Assessment, dated 8/20/24, e no pressure areas. Notes, dated 8/22/24, indicated ure ulcers. Assessment-Team (SWAT) ed 8/22/24, indicated there eers. Note, dated 8/23/24 at 1:08 p.m. estered Dietitian (RD) 6, and informed her there were two kin, on the sacrum and the d Nurse was to evaluate. Mentation of the two open and back in the Nurses' To on 10/29/24 at 10:52 a.m., the RN indicated the meeting on appleted per the phone with the ed RD 6 and she was unable to d her about the open areas,				
	and IN00443034.					

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet

Page 12 of 15

am	T OF PERIOD C	Land and a suppose of the suppose of			712 P. M. AVID	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155251	B. WING		10/29/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8		N 37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE	НОВА			
(X4) ID	SUMMARY	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 APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0880 SS=D Bldg. 00	3.1-50(a)(1) 3.1-50(a)(2) 483.80(a)(1)(2)(4) Infection Prevention		F 0880	Tag# F880 Infection Prevent	tion 10/31/2024	
	Based on observation	on, interview, and record	1 0000	and Control	10/31/2021	
	review, the facility	failed to ensure correct		It is the policy of this facility to	,	
		Equipment (PPE) was used by		ensure that enhanced barrier		
	staff members (CN	A 5, CNA 1, and QMA 2) when		precautions are followed.		
	providing care to re	sidents (Residents E and F)		What corrective actions will	be	
	who were in Enhan	ced Barrier Precautions (EBP)		accomplished for those		
	for two random obs	ervations for infection control.		residents found to be affected	ed	
	Findings include:			by the deficient practice: Resident E and F were asses		
	1) During an observ	vation on 10/28/24 at 8:51 a.m.,		and not negatively affected re to alleged deficient practice by		
	_	gn on the room door that		DON/Designee on 10-28-24.	,	
	· ·	nt was in EBP. There was PPE		How other residents having	the	
	located at the doory	vay to the room. Upon		potential to be affected by the		
		CNA 5 was completing		same deficient practices will		
	morning care on the	e resident. Gloves were worn.		be identified and what		
	_	ad just finished washing him		corrective action will be take	en:	
	and provided incom	tinent care. The feeding tube		All residents who reside in the	•	
		ean. CNA 5 was applying		facility have the potential to be	e	
		it's legs. She indicated the		affected by this alleged deficie	ent	
		ger in EBP and stated, "he		practice, therefore, this plan of	f	
	1	ng, they just forgot to take the		correction applies to all reside	ents	
	_	hen completed the resident's		that reside in the facility.		
	oral care.					
				What measures will be put in	1	
		was reviewed on 10/29/24 at		place and what systemic		
		gnoses included, but were not		changes will be made to		
	limited to, severe pr	rotein deficiency.		ensure that deficient practic	e	
		1 1 10/15/04		does not recur.		
		S assessment, dated 9/15/24,		The DON/Designee in-service		
		rely impaired cognitive status,		nursing staff on 10-31-24 rela	ted to	
	a feeding tube was j	present and supplied 51% or		facility policy and protocol on		

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

Event ID:

54NX11

Facility ID: 000154

If continuation sheet

Page 13 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE	
		155251	B. WI	NG		10/29/2	2024
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDEK OK SUPPLIER			2901 W	37TH AVE		
WATERS	OF HOBART SKIL	LED NURSING FACILITY, THE		HOBAR	RT, IN 46342		
(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		LISC IDENTIFYING INFORMATION		TAG			DATE
		nd 501 cubic centimeters (cc) or			enhanced barrier precautions.		
	more of fluids daily. He was dependent for bathing and required maximum assistance for				Additionally, any staff that fails comply with the points of this	510	
	hygiene.				in-service will be further		
	nygiene.				educated/disciplined as indica	ted	
	A Care Plan. dated	10/28/24, indicated EBP was			Guadated/disorphined as indica	icu.	
		he feeding tube. The			How the corrective actions w	vill	
	_	led EBP guidelines would be			be monitored to ensure the	-	
		t care activities, which			deficient practices will not		
		ygiene, incontinent care.			recur:		
					DON/Designee will complete		
	A Physician's Order	c, dated 10/28/24, indicated			validation of enhanced barrier		
	EBP was to be used every shift due to the feeding				precautions are in place on 10)	
	tube and nebulizer t	reatments.			random staff member weekly :	x	
					4weeks, then 5 random staff		
					members weekly x 4 weeks, the		
	_	vation on 10/28/24 at 9:34 a.m.,			3 random staff members week	dy x	
		the room indicated EBP was			4 weeks then 3 random staff		
	_	nd QMA 2 were prepared to			members monthly x 3 months		
	_	morning care. They had			be completed on. If the facility		
	_	or to the start of the care, they bout EBP. QMA 2 indicated the			within 95% compliance at the		
		P. CNA 1 and QMA 2 then			of 6 months, then monitoring of	can	
		changed gloves. Morning care			be stopped. Results of the monitoring will be reviewed at	tho	
		ich included incontinent care.			monthly QAPI meeting. Any	uie	
	_	f the feeding tube was clean			concerns will have been		
		ssing marked with the date			addressed. However, any patt	erns	
	10/28/24.	6			will be identified. Any needed		
					Action Plan will be written by t		
	Resident F's record	was reviewed on 10/29/24 at			QAPI committee. Any written		
	1:14 p.m. The diagr	noses included, but were not			Action Plan will be monitored	by	
	limited to, stroke an	nd diabetes mellitus.			the Administrator weekly until		
					resolved.		
		um Data Set assessment, dated					
	· ·	e cognition status was not					
		e resident was unable to			Date Of Completion: 10-31-20)24	
	· ·	no behaviors, dependent for all					
		ving, always incontinent of					
		and had a feeding tube					
	present.						

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

PRINTED: 12/04/2024 FORM APPROVED OMB NO. 0938-039

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		
		155251	B. WING		10/29/2024			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
WATERO OF HORART OWN ED AN IROUNO FACILITY THE			2901 W 37TH AVE					
WATERS OF HOBART SKILLED NURSING FACILITY, THE				HOBART, IN 46342				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA) BE)PRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	A Care Plan, dated 10/28/24, indicated EBP was							
	required related to the feeding tube. The							
	interventions included EBP guidelines would be							
	followed with direct care activities, which							
	included, bathing, hygiene, incontinent care.							
	moraded, summig, nygrene, meontment edie.							
	A Physician's Order, dated 2/7/24, indicated EBP							
	was to be used every shift due to the feeding							
	tube.							
	tube.							
	During an interview on 10/28/24 at 10:30 a.m., the							
	Assistant Director of Nursing was informed of							
	EBP not being followed. No further information							
	was received at this time.							
	A facility EBP policy, dated 12/2022 and received							
	from the Minimum Data Set (MDS) Nurse as							
	current, indicated EBP would be used for							
	residents during high-contact resident care							
	activities for residents who were at risk. The							
	residents at risk included residents with feeding							
	tubes. The high-contact examples included							
	bathing/showering, hygiene, and changing							
	briefs/incontinent care. Gowns and gloves would							
	be utilized.							
	This citation relates to Complaint IN00443034.							
	3.1-18(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 54NX11 Facility ID: 000154 If continuation sheet Page 15 of 15