STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. BUILDING 00 B. WING	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY EAST THE	1900 N ALBER ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 18, 19, 20, 21, and 22, 2025 Facility number: 000006 Provider number: 155006 AIM number: 100290220 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 42 Other: 12 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 29, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview, the facility failed to provide a dignified dining experience for 2 of 20 residents observed during meal service in the main dining room. (Residents 22, 45) Findings include: 1. During an observation, on 5/19/25 at 11:54 a.m., Resident 22 sat in a wheelchair at the dining table.	F 0550	**F550 – Resident Rights/Exercise of Rights** It is the policy of this facility to provide a dignified dining experience. **1. Corrective Action for**	06/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Logan Vance	Administrator	06/12/2025

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	Her chair was low in comparison to the table height and put the resident's chin roughly four inches from the top of the table. On 5/19/25 at 12:30 p.m., Resident 22 was sitting very low in a wheelchair. The resident's chin was level with the tabletop. Resident 22 indicated it was difficult for her to eat. On 5/19/25 at 6:06 p.m., Resident 22 sat in a wheelchair at the dining table. She was eating while hunched over and leaning to the right. On 5/21/25 at 8:09 a.m., Resident 22 sat in her wheelchair at the dining table. Her chin was level with the tabletop. Resident 22's clinical record was reviewed on 5/21/25 at 8:55 a.m. Diagnoses included dementia, osteoarthritis, and heart failure. Current orders included a regular diet and may use her personal cup during meals. A 2/19/25, annual, Minimum Data Set (MDS) indicated the resident was cognitively intact. She required setup or clean up assistance with eating. A current care plan, dated 5/20/20, and revised on 9/30/24, indicated the resident needed supervision assistance with eating/drinking. The interventions included required assistance during meals with tray set-up and eating as needed. 2. During an observation, on 5/19/25 at 5:25 p.m., Resident 45 was sitting at the dining table. The resident was low in relation to the table, with her chin roughly four inches above the tabletop. Resident 45 had to reach upward to grab her drink. While drinking, Resident 45's coffee cup was		**Residents Found to Have Been Affected by the Deficient Practice** Resident 45 and Resident 22 were assessed to ensure proper seating and dignified service during mealtimes by the DON/Designee on 06/09/25 All tables were adjusted for proper resident positioning upon notification of height concern by the Maintenance Director/Designee on 06/09/25. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** Residents who dine in the facility dining room have the potential to be affected. A review of dining room seating on 6/6/24 and no further issues were observed by the DON/Designee. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** Staff were in-serviced on 6/9/25 by the DON and Dietary Manager on the policies of Resident Rights and Dignity, with emphasis on table height for residents. Any employee who fails to comply with points of in-service will be further educated and/or disciplined as indicated. **4. How the Corrective**	

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	halfway below the tabletop, then she reached back up and placed the cup back on the table. On 5/19/25 at 5:42 p.m., Resident 45 continued to sit low at the dining table. Her chin was the same height as the tabletop. Resident 45 had to reach up to grab her coffee cup. While drinking, the coffee cup was halfway below the top of the table. On 5/21/25 at 7:34 a.m., Resident 45 was sitting at the table. She was leaning forward while resting her eyes. Her chin was below the tabletop. When Resident 45 took a drink from her coffee mug, the bottom of the mug was below the tabletop. On 5/21/25 at 8:05 a.m., Resident 45 was eating her meal. Her chin was below her plate. Her bottom lip touched the plate when she took a bite of her food. During an interview, on 5/21/25 at 8:10 a.m., CNAs 14, 15, and 16 each indicated they didn't feel it was a problem for either Resident 22 nor 45 to eat with their chin close to the tabletops. They were unsure if the tables could be lowered. Neither resident had ever complained of the table being too high. On 5/21/25 at 8:19 a.m., Resident 45's representative indicated the resident had always sat low to the table since she was admitted to the facility over a month ago. On 5/21/25 at 8:27 a.m., the ADON indicated neither resident had ever complained about the height of the table. She never thought about the height of the table as both residents ate well. She would ask maintenance if they could lower the tables.		**Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** The F550 Dining Room Audit Tool will be completed five days per week for four weeks, then three days per week for four weeks, then monthly for four months for proper table height for residents. The Dietary Manager/designee will be responsible for oversight. If the facility is at or above 95% compliance at the end of six months, monitoring may be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **Date of Compliance:** 6/9/25	

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	Resident 45's clinical record was reviewed on 5/21/25 at 9:00 a.m. Her diagnoses included altered mental status, dysphagia (difficulty swallowing), epilepsy (seizures), and adult failure to thrive. Current orders include mechanical soft diet, ground meat texture, and thin liquids. A 3/28/25, significant change, Minimum Data Set (MDS) indicated the resident was cognitively intact. She required setup or clean up assistance with eating. A current care plan, 1/4/25, revised on 5/22/25, indicated the resident needed supervision assistance with eating/drinking. The interventions included required assistance during meals with tray set-up and eating as needed. During meals, place the food on which the resident should be concentrating on in front. Ensure resident is close enough to the table to reach food/drink properly. A current policy, titled "Guidelines to ensure reasonable accommodation of needs", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...Residents needs and preferences will be honored a much as possible considering each resident's circumstances and overall health status and safety for themselves and others...." 3.1-3(t) 3.1-3(v)(1)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to provide notification of Medicare non-coverage for 2 of 3 residents reviewed for	F 0582	**F582 – Medicaid/Medicare**	06/09/2025

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	Beneficiary Protection Notifications. (Residents 49, 14) Findings include: On 5/19/25 at 2:00 p.m., the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Forms were reviewed and indicated the following: 1. Resident 49 admitted to the facility on 1/7/25 under Medicare Part A Skilled Services. The last covered day for Part A services was 2/19/25. The resident remained in the facility. The clinical record lacked Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN). 2. Resident 14 admitted to the facility on 2/8/25 under Medicare Part A Skilled Services. The last covered day for Part A services was 4/25/25. The resident remained in the facility. The clinical record lacked Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN). During an interview, on 5/19/25 at 2:31 p.m., the Business Office Manager indicated she notified the resident and/or their representative what their private pay amount would be for their room. She had never given any residents an ABN form before. A current policy, titled "Detailed Explanation of Non-coverage", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...The notice explains why your provider and/or health plan decided Medicare coverage for you current services should end.. Detailed explanation of why your services are no longer covered, and the Medicare coverage rules used to make this decision....."		**Coverage/Liability Notice** It is the policy of this facility to provide notification of Medicare non-coverage. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** The BOM/Designee provided resident 49 an ABN for last covered Medicare day of 1/7/2025 on 06/06/25 . Resident 14 no longer resides in the facility. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the same Deficient Practice** The BOM/Designee completed a 90 day look back for residents that were given a last covered day for Medicare A and remained in the facility to ensure an ABN, any concerns were immediately addressed and an ABN provided on 06/06/25. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** Social Services and Business Office Manager were re-educated on proper and timely issuance of NOMNCs and providing an ABN	

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	3.1-4(f)(2) 3.1-4(f)(3)		by the Social Service Consultant/Administrator on 6/9/25 Any employee failing to comply with the in-service may be further educated and/or disciplined as indicated. **4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** *Social Services or a designee will complete the NOMNC/ABN audit tool 5 days a week for four weeks, then 3 days a week for two months, then weekly for three months.* If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **Date of Compliance:** 6/9/25	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation and interview, the facility failed to provide clean equipment for 2 of 19	F 0584	**F584 – Safe/Clean/Comfortable/Homel**	06/09/2025

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	residents reviewed for wheelchair cleanliness. (Residents 22 and 34) Findings include: 1. During an observation, on 5/19/25 at 12:30 p.m., Resident 22's outer left panel of her wheelchair was smeared with a dark substance. During an interview, on 5/19/25 at 6:38 p.m., CNA 11 and CNA 12 indicated third shift CNAs deep cleaned the resident wheelchairs, but it was really every staff member's responsibility. During an observation, on 5/21/25 at 8:16 a.m., Resident 22's wheelchair had honey colored streak marks down the outside panels of her wheelchair. A dark reddish colored substance was smeared over the outer panels of her wheelchair. During an interview, on 5/21/25 at 10:04 a.m., LPN 4 indicated third shift CNAs were responsible for cleaning resident wheelchairs. There was a CNA book at the nurse's station that had the cleaning schedule for resident wheelchairs. Resident 22's wheelchair was scheduled for deep cleanings every Wednesday night. During an observation, on 5/21/25 at 10:13 a.m., Resident 22's wheelchair had a reddish brown substance smeared all over the outer sides of her wheelchair panels. 2. During an observation, on 5/18/25 at 10:21 a.m., Resident 34's wheelchair had a nickel-sized dark brown substance on the right arm pad of her wheelchair. The left side of her seat had a buildup of food particles and stains. On 5/20/25 at 10:39 a.m., Resident 34 was		**ike Environment** It is the intent of the facility to ensure that resident wheelchairs and equipment are maintained in a clean and sanitary condition, and that the facility environment remains safe, clean, comfortable, and homelike. **1. What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice?** The DON/Designee assessed Resident 34 and Resident 22 on 5/23/25, and both residents' wheelchairs were immediately cleaned and sanitized. No negative outcomes were identified. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents utilizing wheelchairs and mobility equipment have the potential to be affected by this cited deficiency. The DON/Designee conducted an audit on 6/6/25 of all resident wheelchairs and equipment and ensured all were cleaned and in good repair. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator/Designee in-serviced all direct care staff and	

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	propelling herself down the hallway. The nickel-sized brown spot on the right arm pad of her wheelchair remained. The left side of her seat had a buildup of food particles and stains. On 5/21/25 at 8:33 a.m., Resident 34's wheelchair still had the nickel-sized brown spot on the right arm pad of her wheelchair. The left side of her seat had a buildup of food particles and stains. During an observation with the ADON, on 5/22/25 at 9:24 a.m., Resident 34's wheelchair had a nickel-sized dark brown substance on the right arm of her wheelchair. On the left side, down the post of the wheelchair, had unidentifiable streaks. There was a nickel sized crumb like substance on her right foot peg. The left side of her seat had a buildup of food particles and stains. Resident 22's wheelchair had a reddish brown food substance smeared all over the outer left and right wheelchair panels. The ADON indicated Resident 22's wheelchair should have been deep cleaned the night prior. A current policy, titled "Guidelines for cleaning DME (Durable Medical Equipment) Wheelchairs/Mechanical Lifts/ Stand up lifts/ shower chairs/ bedside commodes/ walkers/other ", provided by the Administrator, on 5/22/25 at 10:57 a.m., indicated the following: " ...It is policy of the facility to ensure that DME is clean and in good repair ...." 5-1.5(e)		housekeeping staff on the policy for cleaning and maintaining durable medical equipment (DME), including wheelchairs, on 5/29/25. Emphasis was placed on ensuring wheelchairs are cleaned per policy and documentation of completed cleaning is maintained. Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How will the corrective action be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place?** The DON/Designee will audit 10 random resident wheelchairs and mobility devices weekly for 2 weeks, then 5 weekly for 2 weeks, then 3 monthly for 3 months. Results of monitoring will be reviewed at the monthly QAPI meeting. Any concerns will be addressed immediately, and any patterns identified. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Any needed Action Plan will be written by the QAPI committee and monitored by the Administrator weekly until resolved. **Date Corrective Action Will Be Completed:** 6/9/25	
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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Bldg. 00	Based on observation, record review, and interview, the facility failed to implement fall precautions and update care plan interventions following falls for 1 of 2 residents reviewed for accidents. (Resident 41) Findings include: Resident 41's clinical record was reviewed on 5/20/25 at 9:57 a.m. Diagnoses included syncope (fainting) and collapse, repeated falls, chronic kidney disease, and protein-calorie malnutrition. An annual Minimum Data Set (MDS) assessment, dated 2/19/25, indicated Resident 41 was severely cognitively impaired, used a walker and/or wheelchair to ambulate, required supervision when eating, maximum assistance for toileting and showering, was frequently incontinent of both bladder and bowel, had repeated falls, and a history of syncope and collapse. Current orders included padded side rails related to seizure precautions (5/19/25), check wander alert bracelet placement (8/21/24), check bed/chair alarm placement every shift for frequent falls (8/15/24), and acetaminophen 650 mg by mouth every four hours as needed for pain/discomfort (11/2/23). A current care plan, initiated on 5/26/23, indicated the resident required extensive assistance with eating/drinking, bed mobility, and toileting related to cognition deficits, weakness, unsteady gait, and the use of assistive devices. Interventions included an assessment of mobility and level of functioning at least quarterly, encourage and assist to toilet and/or check and change upon rising before and after meals, before laying down	F 0657	**F657 – Care Plan Timing and Revision** It is the policy of this facility to implement fall precautions and update the care plan with interventions after a fall. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** The DON/Designee completed an audit of resident 41's fall precaution interventions and updated the care plan on 06/09/25 **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** The DON/Designee completed an audit of resident's interventions for fall precautions and updated care plans as needed on 06/09/25. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** The ADM/Designee in-serviced the IDT team on updating the residents care plan after Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. How the Corrective Actions Will	06/09/2025

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	at night, and as needed (7/29/24). A current care plan, initiated on 5/26/23, indicated the resident needed extensive assistance with transfers related to weakness, unsteady gait, and the use of assistive devices. Interventions included provide assistance with sit to stand, surface to surface, and balance support. See nurse aide assignment sheet for details on transfer assist as needed and use gait belt for transfers. A current care plan, initiated on 5/22/23, indicated the resident was at risk for falls due to her condition and risk factors of an unsteady gait, with or without assistive devices, use of assistive devices for mobility (walker and wheelchair), weakness, confusion/forgetfulness, and syncope (fainting). Interventions included a bed/chair alarm (4/23/25), call light within reach (5/22/23), do not leave in the bathroom unattended (4/10/25), keep locked wheelchair beside the resident (5/24/23), non-skid strips to front of recliner (7/15/24), pommel cushion to wheel chair (3/21/25), a reminder sign to be hung in room to remind resident to ask for assistance from staff (3/4/24), and staff to toilet resident upon waking, before and after meals, and before laying down for the night (7/25/24). An interdisciplinary team (IDT) general note, dated 12/23/25 at 11:40 a.m., indicated the team reviewed a fall from 12/21/25 at 6:32 a.m. A nurse heard the resident's alarm going off and found Resident 41 in another resident's room on the floor. The resident was assessed, and a new red area was found on the center of her back. No other injuries were noted. The care plan lacked the addition of new interventions after the fall on 12/21/25.		Be Monitored to Ensure the Deficient Practice Will Not Recur The F657 Care Plan Audit Tool will be by the DON/Designee by auditing 10 random residents falls care plans for fall interventions weekly for four weeks, then 5 random residents weekly for four weeks, then 3 random residents weekly for four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** Date of Compliance: 06/09/25	

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	An incident note, dated 3/20/25 at 10:19 p.m., indicated staff entered another resident's room and found Resident 41 on the floor in front of her wheelchair. The resident was alert and confused as per her baseline. She had a red area to her back, approximately 10 centimeters (cm) length x 5 cm width in size. No other injuries were notes. The resident's care plan was updated on 3/21/25 to include a pommel cushion to her wheelchair. An IDT progress note, dated 4/11/25 at 4:17 p.m., indicated the team reviewed the resident's fall on 4/10/25 around 6:15 a.m. Resident 41's bed alarm was alerting, and the third shift nurse went to assist the resident to the toilet. The nurse left the resident in the restroom on the toilet to speak to another staff member. Staff normally are to stay with the resident while on the toilet and assist her safely back to her bed/chair due to the resident's dementia and risk of falls. The resident was found on the floor in front of the bathroom, on her right side. No injuries were noted. The staff member was educated about not leaving the resident alone on the toilet. An incident note, dated 4/13/25 at 1:54 p.m., indicated staff heard the resident's alarm going off and found her sitting on the floor in front of her wheelchair. No injuries were noted. The care plan lacked the addition of new intervention(s) after the fall on 4/13/25. An Interdisciplinary Team (IDT) progress note, dated 5/19/25 at 1:35 p.m., indicated Resident 41 had an unwitnessed fall on 5/19/25 around 5:10 a.m. She was found on the floor by her bed, laying on her left side, with her blankets wrapped around			

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	155006	A. BUILDING 00 B. WING	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY EAST THE	1900 N ALBER ST WABASH, IN 46992

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	her body. She was able to move all her extremities. Neurological checks were initiated, no injuries were noted, and the resident had no complaints of pain or discomfort. The care plan lacked the addition of new interventions after the fall on 5/19/25. During an observation on 5/20/25 at 3:08 p.m., the skid strips in front of the resident's recliner consisted of two squares, each smaller than a sticky-note, approximately 12 inches apart. There was no signage in the room to remind the resident to ask for assistance to ambulate (as indicated on the care plan intervention dated 3/4/24). During an interview with CNA 13 on 5/21/25 at 2:08 p.m., she indicated there was supposed to be a sign in the resident's room to remind her to ask for assistance when getting up from her bed or chair. She thought the non-skid strips were supposed to be bigger than the small squares in front of the resident's recliner. During an interview with CNA 5 on 5/21/25 at 2:10 p.m., she indicated Resident 41 required extensive assistance to ambulate. The squares on the floor should be strips. During an interview with the Assistant Director of Nursing (ADON on 5/22/25 at 2:48 p.m., she indicated a new intervention should be added each time a resident had a fall. The CNA sheet would be updated, and staff would be told about any new interventions during shift changes. During an interview with CNA 25 on 5/22/25 at 2:50 p.m., she indicated aides used care plan sheets to find out about any new interventions for residents.			

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	During an interview with the MDS Coordinator on 5/22/25 at 2:52 p.m., she indicated care plans were updated often. New interventions should be put into place after every fall. A current, undated facility policy titled "Guidelines for Incidents/Accidents/Falls", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...15. Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place...." 3.1-35(e)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to implement interventions to prevent and promote the healing of a pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident 109) Finding includes: During an observation, on 5/19/25 at 9:12 a.m., Resident 109 rested in his bed on his back. During a continuous observation, beginning on 5/20/25 at 2:26 p.m., the resident was lying in his bed on his back. Moon boots (designed to prevent or reduce the risk of pressure injuries) set in a chair beside his bed. At 2:33 p.m., the resident turned on his call light. LPN 4 immediately entered the resident's room, talked with him, then exited his room. At 2:37 p.m., the resident's moon boots remained set on the bedside chair. At 2:42 p.m.,	F 0686	**F686 – Pressure Ulcer Prevention & Treatment** It is the policy of this facility to implement interventions to prevent and promote healing of a pressure injury. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** Resident 109 assessed by the DON/Designee on 06/06/25 and no negative outcome related to the cited practice. **2. How the Facility Will Identify Other Residents Having the Potential to Be**	06/08/2025

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	the resident turned on his call light. At 2:46 p.m., CNA 5 entered the resident's room. She indicated the resident was asleep. The moon boots remained set on the bedside chair. At 3:26 p.m., the resident was lying in his bed on his back, and the moon boots remained set on the bedside chair. During an observation, on 5/20/25 at 4:07 p.m., the resident was lying on his back in bed. The moon boots remained set on the bedside chair. During an observation, on 5/20/25 at 4:12 p.m., LPN 4 entered the resident's room. She uncovered his feet. He had slipper socks on his feet, and his heels were not floated. She indicated the resident should have his moon boots on while in bed. He did not have them on. During an interview, on 5/20/25 at 4:14 p.m., LPN 4 indicated the resident had an order to wear his moon boots while he was in bed. The order was signed off every shift by nursing staff. During an interview, on 5/21/25 at 9:29 a.m., Resident 109's representative indicated the resident often lay on his back for three to four hours while the resident representative visited and was not repositioned. The staff put on the resident's moon boots about half the time while the resident was in bed. The resident had sores on his back, bottom, and heel. Resident 109's clinical record was reviewed on 5/21/25 at 10:27 a.m. Diagnoses included acute respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, chronic kidney disease, anemia, protein-calorie malnutrition, weakness, and fracture of other parts of the pelvis. Current orders included moon boots on while in		**Affected by the Same Deficient Practice** An audit was conducted on all residents at risk for pressure ulcers on 06/09/25to ensure interventions are in place and effective and care plans updated by the DON/Designee. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** The DON/Designee in-serviced staff on pressure ulcer interventions and ensuring interventions are in place. Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** The F686 Skin Integrity Audit Tool will be completed by the DON/Designee by auditing 10 random residents to ensure pressure ulcer interventions are in place weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns**	

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	bed and offload heels every shift (4/2/25), pressure relieving mattress to bed, hydrophilic wound dressing external paste - apply to bilateral buttocks topically every shift for wound care - cleanse, pat dry, apply paste until area resolved (5/16/25), and left heel - cleanse with Dakin's solution (a topical antiseptic) and apply hydrocolloid dressing (a type of wound dressing that creates a moist wound environment, absorbs wound drainage, and can remain in place for several days in a row) every three days (5/16/25). A significant change Minimum Data Set (MDS) assessment, dated 5/7/25 indicated the resident was severely cognitively impaired. He exhibited no behaviors. He had a functional limitation in the range of motion of one lower extremity. He was dependent on the staff for putting on and taking off footwear. He required substantial/maximal staff assistance with toileting hygiene, showering/bathing, upper and lower body dressing, and transfers. He required partial/moderate staff assistance with rolling right and left in bed. He had an indwelling catheter and was occasionally incontinent of bowels. The resident had one stage 3 pressure injury (full-thickness skin loss) that was not present on admission. A current care plan, initiated on 2/18/25, indicated the resident was at risk for skin breakdown related to chronic renal disease, chronic heart disease, edema, and thin/fragile skin. Interventions included assist to toilet and/or check and change frequently (2/18/25), provide peri care as needed (2/18/25), and remind or assist to turn at least every two hours (2/18/25). A current care plan, initiated on 3/26/25 and revised on 4/29/25, indicated the resident had		**will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **Date of Compliance:** 06/09/25	

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	developed a pressure injury to his left heel related to impaired/decreased mobility and decreased functional ability. Interventions included float heels off bed (3/26/25). A 3/21/25 Weekly Wound Evaluation indicated the resident had a suspected deep tissue injury (persistent non-blanchable deep red, maroon or purple discoloration) to his left heel that was 4 centimeters (cm) in length and 3.5 cm in width and black in color. The treatment ordered was to cleanse the area with soap and water, pat dry, and apply povidone iodine. The area was identified on 3/21/25. Current preventative interventions included heel boots. A 3/25/25 Weekly Wound Evaluation indicated the resident had a suspected deep tissue injury to his left heel that was 1 cm in length and 1 cm in width and black in color. The treatment ordered to the area was to cleanse the area with povidone iodine and leave open to air. Current preventative interventions included heel boots. A 4/8/25 Weekly Wound Evaluation indicated the resident had an unstageable pressure injury (obscured full-thickness skin and tissue loss) to his left heel that was 0.8 cm in length and 0.7 cm in width and black in color. The treatment ordered to the area was to cleanse the area with povidone iodine, leave open to air, and offload with moon boot. Current preventative interventions included heel boots. The wound was improving without complications. A 4/15/25 Weekly Wound Evaluation indicated the resident had a stage 3 pressure injury to his left heel that was 0.7 cm in length, 0.6 cm in width, and 0.2 cm in depth. The wound was red with 50% epithelial tissue (cells migrate from wound edge to			

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	cover the wound surface) and 50% granulation tissue (new connective tissue and tiny blood vessels that form on the surface of a wound during the healing process). The treatment ordered was to cleanse the area with Dakin's solution, apply calcium alginate (a wound care product made from brown seaweed) and then apply bordered gauze to the wound every other day. Current preventative interventions included heel boots. The wound was improving without complications. A 5/13/25 Weekly Wound Evaluation indicated the resident had a stage 3 pressure injury to his left heel that was 0.2 cm in length, 0.3 cm in width, and 0.0 cm in depth. The wound was red with 100% epithelial tissue. The treatment ordered was to cleanse the area with Dakin's solution and apply hydrocolloid to the wound every three days. Current preventative interventions included heel boots. The wound was improving without complications. During an observation, on 5/22/25 at 10:06 a.m., the resident was lying on his back in bed. His moon boots were set on the chest of drawers. During an observation, on 5/22/25 at 10:46 a.m., CNA 5 indicated when a resident had heel boots, the boots should be applied while he was in bed. She pulled back the covers. The resident wore slipper socks, no moon boots, and his heels were not floated. During a continuous observation, beginning 5/22/25 at 11:22 a.m., RN 7, after applying a gown and gloves, pulled up the resident's shirt in the back. The area to the resident's back was healed. RN 7 removed the resident's brief. The resident had pasty brown feces on his buttocks. She			

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	provided incontinence care. The resident's buttocks were reddened with a pea sized open area with less than a grain of sugar sized depth near the coccyx area. She applied hydrophilic paste to the buttocks as ordered. She indicated the wound nurse practitioner (NP) had called the area to the buttocks gluteal dermatosis (skin abnormality that isn't inflamed) and utilized the paste for the buttocks since dressings would become soiled easily with incontinence. She removed the moon boot to the left heel to observe the unwrinkled, hydrocolloid dressing that was adhered to the resident's left heel. She indicated the resident had the dressing changed by the wound NP two days ago and was not due to be changed until tomorrow. Throughout the incontinence care and paste application, LPN 8 assisted with holding the resident on his left side. During an interview, on 5/22/25 at 11:37 a.m., LPN 8 indicated the resident should have his moon boots on while he was in bed. During an interview, on 5/22/25 at 2:54 p.m., the DON indicated the resident should wear his moon boots while in bed unless he had refused. If he refused, the refusal should be documented in the resident's record. A review of the resident's clinical record, on 5/22/25 at 2:57 p.m., indicated a lack of documentation of the resident's refusal to allow moon boots to be placed on his feet. An undated facility policy, provided by the Administrator on 5/22/25 at 3:13 p.m., titled "Preventative Skin Care," indicated the following: " ...It is the intent of the facility that the facility provide preventative skin care through careful washing, rinsing, and drying to keep residents			

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	clean, comfortable, well groomed, and free from pressure sores ...Heels up or specialty ordered therapeutic boots may be used to protect heels on those residents identified to be high risk ...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to implement seizure precautions for 1 of 2 residents reviewed for accidents. (Resident 41) Findings include: Resident 41's clinical record was reviewed on 5/20/25 at 9:57 a.m. Diagnoses included syncope (fainting) and collapse, repeated falls, chronic kidney disease, and protein-calorie malnutrition. An annual Minimum Data Set (MDS) assessment, dated 2/19/25, indicated Resident 41 was severely cognitively impaired, used a walker and/or wheelchair to ambulate, required supervision when eating, maximum assistance for toileting and showering, was frequently incontinent of both bladder and bowel, had a history of repeated falls, and a history of syncope and collapse. An Interdisciplinary Team (IDT) progress note, dated 5/19/25 at 1:35 p.m., indicated Resident 41 had an unwitnessed fall that morning around 5:10 a.m. She was found on the floor by her bed, laying on her left side, with her blankets wrapped around her body. She was able to move all her extremities. Neurological checks were initiated, no injuries were noted, and the resident had no complaints of	F 0689	**F689 – Accidents/Supervision/Devices** It is the policy of this facility to implement seizure precautions. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** Residents 41's room was assessed, and all seizure prevention interventions put in place by the DON/Designee on 05/27/25. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** The DON/Designee completed an audit for residents with seizure disorder and implemented seizure precautions as needed on 06/09/25. **3. Measures or Systemic Changes to Ensure the**	06/09/2025

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	pain or discomfort. A general progress note, dated 5/19/25 at 1:35 p.m., indicated Resident 41 had an episode in the dining room at 12:30 p.m. She started jerking and convulsing, her eyes were open and rolled back in her head. Her skin color was gray. Staff stayed with the resident for the duration of the seizure. The seizure lasted approximately 45 seconds to one minute. Afterwards, the resident was alert. She was taken to her room where staff continued to monitor her. A current order, dated 5/19/25, indicated the resident required an assistive device which included two, one-half padded side rails on her bed as a seizure precaution. A current care plan, initiated on 5/19/25, indicated Resident 41 had a need for an assistive bed rail on her bed related to seizure precautions. Interventions included a bed rail screen annually and as needed, ensure proper body alignment in bed, and ensure the resident was not placed too close to either side of her bed. The resident was to be instructed on the use of her call light, reminded to call for assist with transfers, and notify the Physician of any change in condition. A current care plan, initiated on 5/19/25, indicated Resident 41 had a diagnosis of seizure/tremor and was at risk for injury. Interventions included the administration of medications as ordered, monitor pertinent labs, and notify the Physician if seizure activity increased. Side rails were to be padded as needed and the onset, duration, and description of any seizure/tremor activity was to be recorded. During an observation on 5/20/25 at 10:25 a.m., Resident 41's side rail to the outside of her bed		**Deficient Practice Does Not Recur** Nursing staff were education on implementing seizure precautions by the DON/designee on 5/29/2025. Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur The F689 Safety Device and Supervision Audit Tool will be completed 5 days weekly for four weeks, 3 days weekly for four weeks, then weekly for four months for implementation of seizure precautions are in place for residents with seizure disorder. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** Date of Compliance: 06/09/25	

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	was padded with a gray pool noodle. It was approximately the length of two rulers and covered the center of the bed rail, exposing some of the bedrail at the head of the bed and the bottom of the rail. The inside bed rail, against the wall, was up and had not been padded. During an interview with CNA 5 on 5/21/25 at 2:10 p.m., she indicated she did not know if there should be padding on both rails for seizure precautions. During an interview, on 5/21/25 at 2:18 p.m., CNA 5 indicated both rails should be padded. During an interview on 5/21/25 at 2:51 p.m., the DON indicated the maintenance person had not known how to install pads to side rails because it was uncommon for the facility to use seizure precautions. A current, undated facility policy, titled "Seizure Precautions Guidelines for Care" and provided by the Administrator on 4/22/25 at 4:20 p.m., indicated the following: "...It is the policy of this facility to protect the resident from injury during a seizure and to evaluate and document observations prior to, during, and after a seizure...." The policy lacked instructions for side rail pad application. 3.1-45(a)(2)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff Based on interview and record review, the facility failed to ensure the Dietary Manager completed the required education to meet the qualifications for a Dietary Manager. This deficiency had the	F 0801	**F801 – Qualified Dietary Staff** It is the policy of this facility to	06/09/2025

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	potential to impact 56 of 56 residents who received meals from the facility kitchen. Findings include: During an interview on 5/18/25 at 9:49 a.m., the Dietary Manager indicated she did not have a certification qualifying her to act as Dietary Manager. She was hired in December of 2024 and had received no training at that time, or since. During an interview with the Administrator on 5/20/25 at 11:48 a.m., he indicated he was aware the Dietary Manager was not certified to act as Dietary Manager. During an interview with the Regional Director of Operations on 5/20/25 at 12:07 p.m., he indicated he was aware the Dietary Manager was not certified to act as Dietary Manager. He planned to enroll her in an appropriate training program to get her certification. He was aware she had been employed as the Dietary Manager since December of 2024. A current facility policy, dated 11/3/17, titled "Food & Nutrition Department Staffing", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...The facility will maintain sufficient and competent qualified staff to meet the residents needs...to ensure there is sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services...The facility will employ a Qualified Food Service Director per regulatory requirements...." Cross reference F804. Cross reference F812.		ensure the Dietary Manager has completed the required education to meet the qualifications for a dietary manager, **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** Dietary Manager was educated and received her ServSafe certificate on 06/20/25 **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** All residents have the potential to be affected by this practice, therefore, this plan of correction applies to all residents that reside in the facility. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** The Administrator/Designee in-serviced dietary management on 6/9/2025 on education requirements related to be a qualified dietary manager . Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur**	

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	155006	A. BUILDING 00 B. WING	05/22/2025

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	3.1-20(e)		The F801 Dietary Staffing Audit Tool will be completed monthly x 6 month, verification that Dietary Manager has the qualification to be a Dietary Manager. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** Date of Compliance: 06/09/25	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review the facility failed to ensure meals were palatable for 17 of 31 residents reviewed for palatable meals. (Residents 3, 4, 5, 9, 17, 19, 23, 25, 33, 34, 36, 40, 49, 50, 51, 108, and 109) Finding includes: During an interview, on 5/18/25 at 11:04 a.m., the Resident 109's representative indicated the food at the facility was terrible. The resident's representative had talked with the Administrator and sent a letter to the vice president of the	F 0804	**F804 – Nutritive Value/Appealing/Palatable/Temperature** It is policy of this facility to ensure melas are palatable. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** The DON/Designee assessed Residents 3, 4, 5, 9, 17,19, 23,	06/09/2025

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	company. The food was worse than terrible. The roll yesterday was as hard as a rock. He could bounce it off the floor. The residents were served some kind of soup yesterday and were unable to tell what it was supposed to be. The food was cold, did not look good, and tasted terrible. He sent back the resident's breakfast three days in a row because it was cold and looked terrible. Sometimes, there was very little on the plate. One time, there was just a hot dog on the plate. He kept hearing everyone's hands were "tied" when trying to make the food more pleasing During an interview, on 5/18/25 at 11:13 a.m., Resident 36 indicated the food "sucked" and looked "disgusting". The food either had no taste or had too much spice. The facility served lentil soup last evening. It had no flavor and did not look good. The plates looked like "slop". The residents complained, but nothing changed. The food was always cold. During an interview, on 5/18/25 at 2:24 p.m., Resident 40 indicated the food was not good at all. The food was cold, did not taste good, and looked "nasty". During an interview, on 5/18/25 at 3:11 p.m., Resident 49 indicated she often went back to her room to eat snacks and food provided by her family because the facility's food was not good. During an interview, on 5/19/25 at 9:56 a.m., Resident 3 indicated the food was "awful". During an interview, on 5/19/25 at 10:11 a.m., Resident 108 indicated the taste of the food varied and depended on who the cook was. The food taste had really slipped and did not taste good at all. Sometimes it was warm when served, and		25, 33, 34, 36, 40, 49, 50, 51, 108, and 109 on 06/09/25 and no negative outcome related to the cited practice. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** All residents have the potential to be affected by the alleged deficiency, therefore, this plan of correction applies to all residents that reside in the facility. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** Dietary staff were in-serviced on meal quality standards, food temperature checks, serving portions and palatability standards. Any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** The F804 Meal Quality Audit Tool will be completed by the ADM/Designee by interviewing 10 random residents a week x 4 weeks on food palatability, position sizes, and temperatures, then5 random residents weekly x	

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	sometimes it was cold. She often had her family bring in food for her. During an interview, on 5/19/25 at 11:26 a.m., Resident 50 indicated most of the food was cold when he got it. Yesterday, the facility had served lentil soup, so he had his wife bring him something later from a restaurant. During an interview, on 5/19/25 at 12:17 p.m., Resident 25 indicated sometimes the food did not taste good. The quantity was not good either. A sandwich and some fruit was all she got for supper sometimes. The food was cold by the time she got her tray in her room. The staff warmed it up if she wanted. She had eaten sausage gravy this morning, and it was the first time it was hot. The nurse had gotten it before others started eating and brought it to her since she had an appointment in the morning. When she got soup, the soup bowls were maybe half filled. One night, she had a piece of pizza so small it fit in a bowl, and half of a dessert dish of fruit. The last month, the food had gotten worse. During an interview, on 5/19/25 at 12:39 p.m., Resident 9 indicated she had been taking notes about the food and the various issues with it. On 5/9/25, she received her supper at 6:20 p.m., although dinner was supposed to be served at 5:00 p.m. On 5/12/25, she received minestrone soup for dinner, which was only half a bowl. She had to fill up on snacks because the dinner was not enough food. On 5/13/25, for lunch, she received very little of the pudding; the dish was not even filled halfway up. On 5/14/25, for lunch she had a small portion of goulash and a very hard roll, which she called a "hockey puck". For dinner, she had cold French fries and a carrot and raisin salad that was bad. On 5/15/25, for dinner		4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** Date of Compliance: 06/09/25	

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	she received one taco with lettuce, tomato, a little meat, and a cookie. She felt it was very little food to receive. During an observation, on 5/19/25 at 5:14 p.m., drinks passed to the residents contained very little ice. During an observation, on 5/19/25 at 5:29 p.m., CNA 12 indicated to the residents the meat loaf, which was on the menu, was made with turkey. During an observation, on 5/19/25 at 5:36 p.m., pudding portions were not consistent. One resident received a full dish of pudding; another resident had requested pudding and received a dish less than half filled. During an interview, on 5/19/25 at 6:06 p.m., Resident 9 indicated the meal was warm but not hot tonight. The biscuit was only the size of a silver dollar. During an interview, on 5/19/25 at 6:08 p.m., Resident 49 indicated she did not like the meat loaf. She ate one bite. On 5/19/25 at 6:29 p.m., a test tray was observed. The meat loaf was grayish in color with lots of ketchup on the top,and the flavor was displeasing. The mashed potatoes and gravy were not flavorful. The cranberry juice was watered down and lacked flavor. Facility grievances provided by the Administrator on 5/20/25 were reviewed and indicated the following: Resident 33, on an undated grievance, indicated the food was "lousy, lousy, lousy." The food was			

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	poorly cooked and was not provided enough food to fill her up. Resident 23, on a grievance dated 12/2/24, indicated the cream of wheat was too thick, and the pancakes were too thick. Resident 109's representative, on a grievance dated 2/27/25, indicated the resident only received two chicken wings and was supposed to get four. He also received applesauce instead of the apple pie on the menu. Resident 109's representative, on a grievance dated 4/29/25, indicated the supper ticket listed hamburger on a bun, but the resident received a bologna sandwich. The French fries were not cooked through. The meals were usually not warm and had to be sent back to be heated. Resident 5, on a grievance dated 4/29/25, indicated the French fries were not cooked through. There were not enough hamburgers to serve everyone, so some people got bologna instead. Resident 51, on a grievance dated 4/30/25, indicated the evening meal was a chicken pot pie and crushed pineapple. The food served made her feel like older people did not matter. Resident 40, on a grievance dated 4/30/25, indicated the food tasted like "s**t." Resident 49, on a grievance dated 4/30/25, indicated the French fries were never done. The meat loaf tasted like a big chunk of hamburger with no seasoning. Resident 17, on a grievance dated 4/30/25,			

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	indicated he received a bowl of crap for dinner. He ate two bags of fried cheese puffs and some crushed pineapple. He had another meal that was egg salad sandwiches and was still hungry after he ate. Resident 4, on a grievance dated 4/30/25, indicated the food was terrible. She wondered why the facility couldn't get someone who could cook. Resident 19, on a grievance dated 4/30/25, indicated the food was not very good and needed improvement. He could not eat his dinner on 4/30/25. Resident 3, on a grievance dated 4/30/25, indicated the food was terrible and looked bad - messy. Resident 25, on a grievance dated 4/30/25, indicated she received a bowl with a two-inch piece of pizza and a bowl of pear cubes. She was glad she had some chicken strips in her refrigerator she had gotten when she was out of the facility the day before. The meals were bad. Resident 9, on a grievance dated 4/30/25, indicated the supper portion of potpie was very small. She only took three bites and that was all there was. She often received cornbread without butter and chili without chili seasoning. A review of the Resident Council minutes, provided by the Social Services Director (SSD) on 5/20/25, indicated in the meeting on 4/9/25 the residents had complained that the supper was getting later and later, the baked potatoes were served with no butter and no sour cream. In the meeting, on 5/7/25, the residents' complaints			

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	about the food were still an issue including the not getting bread when on the menu, the hamburger was not good, and the salad lettuce was brown. During an interview, on 5/20/25 at 10:59 a.m., the Administrator indicated he was working with the resident on the food complaints. There was a food committee developed to discuss the residents food concerns. During an interview, on 5/20/25 at 12:07 p.m., the Regional Director of Operations for the contracted company supplying the facility dining services indicated he had spoken with the Resident Council and had received good feedback. He knew residents were dissatisfied with the portions and the temperatures of the food. There were some new dietary staff members, and he was making sure they were getting educated. The company tried to customize the menu from facility to facility. For example, he was taking the lentil soup and the turkey loaf off the menu. Anonymous interviews were conducted during the survey as follows: Interviewee B indicated the food had been "sucking." The portion sizes were inconsistent. Interviewee C indicated the food was more often worse than good. Interviewee D indicated she would not eat the food and the portions were small. Interviewee E indicated she had talked to the Administrator about the food. The food was not good.			

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	Interviewee F indicated the food was subpar in temperatures, portion sizes, presentation, and taste. A facility policy, revised on 3/7/25, provided by the Administrator on 5/22/25 at 3:35 p.m., titled "Meal Service - Palatability and Nutritive Value," indicated the following: " ...Food will be prepared, held, and served in a manner that maintains its nutritive value and palatability ...." Cross reference F801. 3.1-21(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to store and prepare food under safe and sanitary conditions related to kitchen equipment, utensil storage, food storage, and chemical storage. This deficient practice had the potential to affect 56 of 56 residents who received food from the facility kitchen. Findings include: During a kitchen observation on 5/18/25 at 9:49 a.m., accompanied by the Dietary Manager, the following was observed: Next to the front service window, an open container of brown sugar was on the countertop with a scoop (including the handle) laying inside the brown sugar. The microwave had splatters of eggs and other unidentifiable foods on the bottom, three inside walls, and inside the door. The many food	F 0812	**F812 – Food Procurement, Store/Prepare/Serve-Sanitary** It is the policy of this facility to store and prepare food under safe and sanitary conditions related to kitchen equipment, utensil storage, food storage and chemical storage. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** The Dietary Manager/Designee discarded the brown sugar, cleaned the inside of the microwave and the upper cabinets were cleaned, placed the gloves	06/09/2025

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	155006	A. BUILDING 00 B. WING	05/22/2025

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	splatters varied in size and were dry and thick in appearance. The upper cabinets to the left of the service window contained different colored splatters on the outsides of the doors. Splatter sizes ranged from the size of a dime to the size of a quarter. Under the cabinets, a pair of discarded kitchen gloves lay on the countertop along with three empty coffee packets. The floor beneath the cabinets and countertop was covered with corn flakes, about the size of a floor mat. The toaster had a thin layer of crumbs on the spill tray, with crumbs on the countertop beneath the toaster. There were scissors laying in the crumbs. There was an uncovered container of melted butter on top of the toaster. The front of the stainless-steel refrigerator had thick, finger sized, sticky prints covering the areas above, below, and beside the handles. Inside the refrigerator was a roast beef (identified by the Dietary Manager) in a zip lock bag dated 5/5/25. The Manager removed the meat and threw it away. The top utensil drawer on the single sink station, containing spatulas and tongs, had crumbs and nickel-sized drips of an unidentifiable, brown substance on the bottom. The bottom utensil drawer contained measuring utensils with crumbs and a piece of torn paper on the bottom. There was an open 25-pound bag of panko breadcrumbs sitting on a rolling bin underneath the counter where the food processor was located.		and empty coffee packets in the trach that were under the cabinets, swept the floor under the cabinets, cleaned the crumbs out of and around the toaster, disposed of the container of melted butter, cleaned the front of the refrigerator, cleaned the crumbs out utensil top and bottom utensil drawers, washed the utensils, disposed of the panko bread crumbs, removed the bleach containers for the storage area, and educated the staff member that touched the green beans with the lid on 6/9/2025. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** All residents have the potential to be affected by this alleged deficiency, therefore, this plan of correction applies to all residents that reside in the facility. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** All dietary staff were in-serviced on safe food storage, cleaning protocols and checking for expired items on 6/9/25. Any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How the Corrective**	

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	155006	A. BUILDING 00 B. WING	05/22/2025

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	In the dry storage area, to the left of the entrance, two containers of bleach and approximately six boxes of sanitizer and floor cleaner sat on the floor beneath two electrical panels. During an observation on 5/19/25 at 11:39 a.m., a kitchen staff member emptied a large can of green beans into a stainless-steel container in preparation for heating. The lid of the green beans was not completely removed. As she shook the can to empty the green beans, the inside and outside of the lid touched the green beans repeatedly. The Dietary Manager indicated the lid should have been removed completely and the staff member had not been trained properly. During an observation on 5/19/25 at 11:45 a.m., the chemicals in the dry storage area remained in their same position beneath the electrical panels. During an observation and interview on 5/21/25 at 9:34 a.m., the Regional Director of Operations indicated the chemicals should be stored properly in the janitor's closet. He pointed to the closet approximately 4 to 5 feet from where the chemicals sat. He planned to train the staff on proper kitchen cleaning and storage of chemicals. A current facility policy, dated 3/25/12, titled "Cleaning & Sanitation", provided by the Administrator on 5/22/25 at 10:47 a.m., indicated the following: "...The Food and Nutrition Director will develop, implement, and monitor schedules for cleaning, sanitizing, and maintenance and keep record for 1 year...To ensure the food service department is maintained according to state and federal regulations and is a clean, sanitary, and safe environment at all times...1. The Food Service Director develops, implements, and monitors a cleaning schedule to include all areas of the		**Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** The F812 Food Safety Audit Tool will be completed five times per week for four weeks, then three times per week for four weeks, then weekly for four months for kitchen and equipment cleanliness and food storage. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** Date of Compliance: 06/09/25	

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	kitchen and equipment. 2. Food Service employees are trained in proper use, cleaning, and maintaining all equipment. 3. Cleaning schedules designate cleaning for each position and are posted in an accessible area...." A current facility policy, dated 3/25/12, titled "Food Storage", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...Food is stored and prepared in a clean, safe, sanitary manner that will comply with state and federal guidelines...to minimize contamination and bacteria...1. Food storage areas are clean, organized, and free of dirt...4. Containers for bulk items (flour, sugar, etc.) are leak proof, non-absorbent, sanitary, NSF approved and have tight fitting lids... 5. All food not in original containers are to be labeled and dated and stored in NSF approved containers...." A current facility policy, dated 3/25/12, titled "Safe Food Handling Practices", provided by the Administrator on 5/22/25 at 10:57 a.m., indicated the following: "...All food is purchased, store, prepared, and distributed in a clean, safe, sanitary manner promoting safe food handling and compliance with state and federal guidelines...To minimize contamination and bacteria while providing nutritious meals...6. All working surfaces and equipment are clean and sanitized after each use...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to consistently implement facility policy for enhanced barrier	F 0880	**F880 – Infection Prevention & Control**	06/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. BUILDING 00 B. WING	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY EAST THE	1900 N ALBER ST WABASH, IN 46992

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	precautions for staff to identify those residents requiring enhanced barrier precautions for 1 of 3 residents reviewed for enhanced barrier precautions. (Resident 21) Finding includes: During an observation, on 5/19/25 at 9:15 a.m., Resident 21 lay on his bed on top of the blankets looking at a phone. A heel boot was lying on the floor beside the bed. No signage for transmission-based precautions was on his door During an observation, on 5/20/25 at 9:49 a.m., Resident 21 sat in his wheelchair in his room with a heel boot on his right foot. No signage for transmission-based precautions was on his door. During an observation, on 5/21/25 at 9:19 a.m., Resident 21 sat in his wheelchair in his room. He had a heel boot on his right foot. No signage for transmission-based precautions was on his door. Resident 21's clinical record was reviewed on 5/20/25 at 3:26 p.m. Diagnoses included chronic diastolic (congestive) heart failure, peripheral vascular disease, multiple myeloma, and protein calorie deficit. Current orders included enhanced barrier precautions related to his wound with personal protective equipment (PPE) outside door, bin in room for disposal, and sign on door every shift (5/8/25) and cleanse wound to right foot with Dakin's solution, pat dry, apply calcium alginate with silver, and cover with bordered foam dressing every other day until resolved (5/14/25). A 2/26/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately		It is the policy of this facility to consistently implement enhanced barrier precautions. **1. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice** The DON/Designee assessed Resident 21 on 06/06/25 and no negative outcome related to the cited practice. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice** The DON/Designee completed an audit for residents that required Enhances Barrier Precautions and placed signs on doors as needed on 06/09/25. **3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur** Staff were educated on Enhanced Barrier Precautions by the Infection Preventionist on 5/29/25. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4. How the Corrective Actions Will Be Monitored to Ensure the Deficient Practice Will Not Recur** The F880 Infection Control Audit Tool will be completed five times	

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	cognitively impaired. He required partial/moderate staff assistance for rolling left and right in bed. He required substantial/maximal staff assistance with toileting, showering/bathing, upper/lower body dressing, and transfers. He was dependent on staff for putting on and taking off footwear. A care plan, initiated on 5/8/25, indicated the resident had developed an arterial wound to his right lateral foot. A care plan, initiated on 5/18/25, indicated the resident was on enhanced barrier precautions related to wounds or a skin opening requiring a dressing. Interventions included set up isolation per facility protocol and follow enhanced barrier precautions (5/18/25). A Wound Assessment Report, dated 5/13/25, indicated the resident had an arterial wound to his right later foot with a length of 1.0 centimeters (cm), a width of 1.0 cm, and a depth of 0.2 cm. During an interview, on 5/22/25 at 11:44 a.m., CNA 16 indicated she knew which residents were on enhanced barrier precautions and required PPE by the signs on the doors. They also had a PPE cart beside their door or across the hall in front of their door. She knew what PPE was required for the resident by the signs on the doors. She walked down the hall and pointed to all the doors with signs on them as residents who required enhanced barrier precautions. She indicated Resident 21 was not on any transmission-based precautions. He did not have a sign on his door. She thought the enhanced barrier precautions were also listed on the CNA assignment sheets. She looked at the CNA assignment sheets and indicated transmission-based precautions were not on the assignment sheets for anyone.		per week for four weeks, three times per week for four weeks, then monthly for four months for residents that require Enhanced Barrier Precautions and signs placed on residents doorways. Reviewed at QAPI monthly, compliance threshold 95%. **Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **Date of Compliance: 06/09/25** **Responsible Party:** DON/Infection Preventionist/Designee	

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	During an interview, on 5/22/25 at 11:48 a.m., the Infection Preventionist (IP) indicated she had not put the enhanced barrier precautions sign on the door. The resident had been recently added to the enhanced barrier precautions list. During an interview, on 5/22/25 at 11:50 a.m., CNA 18 indicated she knew the resident required PPE when doing care because he had a wound, but he did not have a sign on his door. During an observation, on 5/22/25 at 11:57 a.m., the Housekeeping Supervisor placed bins in the room for disposal of PPE/trash/laundry. The resident did not have the facility bins that were utilized for the enhanced barrier precautions in his room prior to this placement. During an interview, on 5/22/25 at 2:52 p.m., the DON indicated the resident should have had the EBP signage on his door as ordered. A facility policy, revised 12/2022, provided by the Administrator on 5/22/25 at 3:13 p.m., titled "ENHANCED BARRIER PRECATIONS-(EBP)," indicated the following: " ...Procedure ...3) Ensure that proper signage is posted on the resident's room door instructing those who plan to enter the room to check first at the Nurses' Station for education/instructions...5) Ensure that proper receptacles are in place to collect discarded EBP in the resident's room ...." 3.1-18(a)			