STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00454200 and IN00453772. Complaint IN00453772 - Federal deficiencies related to the allegations are cited at F691. Complaint IN00454200 - No deficiencies related to the allegations are cited. Survey dates: March 10, 11, 12, 13 and 14, 2025 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Census Bed Type: SNF/NF: 71 SNF: 12 Total: 83 Census Payor Type: Medicare: 12 Medicaid: 59 Other: 12 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 3/21/2025	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 04/14/2025. The facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility	F 0578	It is the policy of this facility to	04/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	failed to ensure a resident's choice of Advance Directive was documented consistently in the medical record and staff were aware of the resident's choice for 1 of 1 residents reviewed for Advance Directives (Resident 31). Findings include: During a record review for Resident 31, completed on 3/11/25 at 9:22 A.M., the following conflicting information regarding the resident's advance directives/code status was noted: the face sheet indicated the resident was a "Do Not Resuscitate (DNR)". However, the physician's orders included orders indicating the resident was a DNR and a Full Code (initiate life sustaining measures, such as chest compressions if heart stops). A Indiana Physician Orders for Scope of Treatment (POST) form dated and signed on 2/20/2025 for Resident 31, indicated the resident wanted to be a full code. The current Care Plan for Resident 31, dated 3/4/2025, indicated a code status of DNR. During an interview, on 3/11/2025 at 1:11 P.M., LPN 8 indicated a resident's code status located on the face sheet and if it was not listed on the face sheet, facility staff were to look in the resident's physician's orders or documents. LPN 8 confirmed the code status for Resident 31 on the face sheet, physician orders, and POST were conflicting and did not match. During an interview, on 03/11/25 1:17 P.M., the DON indicated Resident 31 had recently changed her code status. The DON indicated the code status should have been updated and confirmed the clinical record did not match Resident 31's		ensure a resident’s choice of Advance Directive is documented consistently in the medical record and staff are aware of the choice¿ ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ The SSD/Designee updated resident 31’s Advance Directive in the medical record, physician order, POST form and care plan to DNR status on 03/14/2025.¿ Statement 1 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?¿ The SSD/Designee complete an audit of residents Advanced Directives for accuracy of physician order, POST form and care plans on 03/14/2025, any concerns were immediately addressed. Statement 1 ¿ What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee educated staff on the policy “Advanced Directives and Procedure, including completion of a POST form with changes, physician orders and care plans related to Advanced Directives initiated on 3/14/2025. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as	

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	current code status. A current facility policy was provided by the Regional Nurse, on 3/13/2025 at 2:35 P.M. The policy titled, "Advanced Directives Policy and Procedure" indicated "..the facility provides residents the right to accept or refuse treatment and formulate advanced directives..." 3.1-4 (f) (5)		indicated.¿Exhibit J & Ja How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The SSD/Designee will audit 10 random residents Advanced Directive for accurate physician orders, POST Form and care plan weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random resident monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿Exhibit A Desk Review requested	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, interview and record review the facility failed to follow a Physicians order to hold a hypotensive medication (Resident 24), failed to keep a complete hospice binder (Resident 55), failed to follow physician's orders regarding hypertensive medication (Resident 6), failed to provide recommended emollient for skin	F 0684	It is the policy of this facility to follow physician orders to hold medications, to keep a complete hospice binder, to follow physician orders for hypertensive medications, to provide emollients for skin, and to provide sliding	04/14/2025

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	(Resident 39), and failed to provide sliding scale insulin for 2 day for a resident with diabetes mellitus (Resident 331). Finding includes: 1. The record for Resident 24 was reviewed on 3/12/2025 at 9:43 A.M. Diagnoses included but were not limited to: pulmonary hypertension, orthostatic hypotension, obesity, congestive heart failure, and anxiety. Physician Orders included but were not limited to: carvedilol 3.125 milligrams (mg) daily, torsemide 10 mg daily, and midodrine 5 mg three times a day, hold for systolic blood pressure (SBP) greater than 120. The Medication Administration Record MAR for January 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 42 times. The MAR for February 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 28 times. The MAR for March 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 7 times. During an interview on 3/12/2025 at 2:34 P.M., Regional Nurse indicated on the days with SBP greater than 120, the midodrine should not have been administered. During an interview on 3/13/2025 at 10:41 A.M., LPN 7 indicated if Resident 24's SBP was greater than 120 the facility staff should not have administered the medication. 2. A record review		scale insulin.¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ The DON/Designee assessed resident #24, #331 and # no negative outcome related to the alleged cited deficient practice on 3/14/2025 and notified the residents physician of medications administered or no administers per parameters on 3/19/2025.¿ The DON/Designee notified resident 55's hospice provider and created a binder with medications, Advanced Directive, and hospice visits since January 17, 2025, on 03/14/2025.¿ The DON/Designee notified the Nurse Practitioner on 3/19/2025. Resident # 30 no longer resides at the facility. Statement 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?¿ The DON/Designee audited resident with medication parameters and notified the physician of any medications administered outside the parameters on 3/19/2025.¿ The DON/Designee audited residents with hospice services for hospice binders and documentation on 3/14/2025. C, Statement 15¿ The DON/Designee completed a 30 day look back of the skin and wound progress notes for	

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	was completed for Resident 55 on 3/13/2025 at 11:32 A.M. Diagnoses included, but were not limited to: senile degeneration of the brain and dementia. A Quarterly MDS (Minimum Data Set) assessment, dated 2/10/2025 indicated Resident 55's cognition was significantly impaired. A significant changed MDS was completed on 1/26/2025 indicating the resident was receiving hospice services. A Physician's Order, dated 1/15/2025 indicated hospice was to evaluate and treat the resident per family request. A Physician's Order, dated 1/17/2025 indicated Resident 55 was accepted to (name of hospice) and was a DNR (do not resuscitate). A current Care Plan, revised on 1/20/2025 indicated Resident 55 elected hospice services and was to be followed by hospice care (name of hospice). Interventions included, but were not limited to: Staff nurses will contact hospice with information that affects resident care. On 3/13/2025 at 1:35 P.M., a review of Resident 55's hospice book was completed. The resident's hospice book lacked documentation of the resident's medications, physician's orders, a signed DNR and any communication between the facility and (name of hospice). During an interview on 3/13/2025 at 1:38 P.M., the DON indicated the resident's hospice book should have had a copy of the resident's signed DNR, current orders, medications and any communication between the facility and (name of hospice).		recommendations and verified orders in place on 3/14/2025. Any concerns were immediately addressed.¿¿Statement 3 & Statement 4 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee in-serviced the nursing staff on following physician orders related to parameters, updating hospice binders with provider visits, and reviewing and implementing recommendations from skin and wound progress notes on 3/18/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.¿Exhibit J How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will audit 10 random residents for following parameters for medications weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random residents monthly x 4 months.¿¿ The SSD/Designee will audit hospice residents' binders 5 times a week x 4 weeks for visit documentation, then 3 times a week x 4 weeks, then once a week x 4 months.¿ Exhibit B ¿ The DON/Designee will audit the Nurse Practitioners skin and	

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	On 3/13/2025 at 2:16 P.M., the DON provided a policy titled, "Guidelines for Palliative Care-Hospice Care," dated 10/9/2024 and indicated it was the policy currently being used by the facility. The policy indicated, :..What must a LTC facility do as their part for partnering with the hospice provider? D. A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the residents are addressed and met 24 hours per day...." 3. A record review was completed for Resident 6 on 3/11/2025 at 1:09 P.M. Diagnoses included, but were not limited to: atrial fibrillation, coronary atherosclerosis and hypertension. A Physician's Order indicated Resident 6 was to receive Triamterene and Hydrochlorothiazide 37.5-25 mg (milligram) tablet by mouth, one time a day for hypertension. The medication was to be held if the resident's systolic blood pressure was below 110 mmHg (millimeters per mercury). A review of Resident 6's MAR (medication administration record) indicated the Triamterene and Hydrochlorothiazide 37.5-25 mg tablet was documented as given on the following dates, when the resident's blood pressure was outside the recommended parameter: - on 11/21/2024 the resident's blood pressure was 100/50 mmHg. - on 11/22/2024 the resident's blood pressure was 102/54 mmHg. - on 12/11/2024 the resident's blood pressure was 97/53 mmHg. - on 12/22/2024 the resident's blood pressure was		wound progress notes for recommendations and implementation of recommendations once a week x 6 months.¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿Exhibit G Desk Review secondary to no harm cited with limited scope	

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	108/62 mmHg. - on 1/4/2025 the resident's blood pressure was 102/60 mmHg. - on 1/21/2025 the resident's blood pressure was 88/58 mmHg. - on 2/1/2025 the resident's blood pressure was 91/52 mmHg. - on 2/16/2025 the resident's blood pressure was 105/58 mmHg. During an interview on 3/12/2025 at 1:53 P.M., the DON indicated the resident's medication should have been held on the days her blood pressure was outside the recommended parameters. On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, "Guidelines for Physician Orders-Following Physician Orders," dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated, "...4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received...." 4. During an interview, on 3/10/2025 at 11:09 A.M., Resident 30 indicated she had very dry skin. A record review for Resident 30 was completed, on 3/13/2025 at 9:17 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and hemiplegia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/11/2025, indicated Resident 30 had moderate cognitive impairment and impaired range of motion to the upper and lower extremities on one side of her body. A Nurse Practitioner Skin and Wound Progress Note, dated 2/28/2025 at 9:26 A.M., indicated			

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	Resident 30's skin was dry, flaky and atrophied and was observed to have dry skin generalized to her entire body. An "emollient skin application as needed for dry and/or atrophic skin" was recommended by the nurse practitioner.However, there were no orders for an emollient to be provided to Resident 30 for her dry skin. A Care Plan, initiated 5/10/2025 and revised on 8/13/2024, indicated Resident 30 was at risk for additional areas of skin breakdown. The goal included, but was not limited to: Resident 30 would be provided with preventative measures to avoid skin breakdown. Interventions included, but were not limited to: monitor skin daily during care and notify the physician and family of any change in skin integrity. During an interview, on 3/14/2025 at 10:14 A.M., the Director of Nursing (DON), indicated Resident 30 should have had an order for an emollient if recommended by the nurse practitioner. During an interview, on 3/14/2025 at 11:19 A.M., the Regional Director of Clinical Services indicated the emollient for Resident 20 would have been ordered as needed if an issue of her skin arose. A policy was provided, on 3/14/2025 at 1:00 P.M., by the Director of Nursing. The policy titled, "Guidelines for Preventative Skin Care", indicated, " ...Procedure: 1) Appropriate skin care is provided by staff each shift and/or as necessary ...." 4. During an interview, on 3/10/2025 at 11:41 A.M., Resident 331 indicated the meals provided by the facility were high in carbohydrates and her blood sugars had been running high since her admission			

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	to the facility. A record review for Resident 331 was completed on 3/12/2025 at 10:03 A.M. Diagnoses included, but were not limited to: pathological fracture of left femur, malignant neoplasm of liver and lower lobe of left bronchus, secondary malignant neoplasm of bone and diabetes mellitus type 2. Resident 331 admitted to the facility on 3/7/2025. The Admission MDS assessment had not yet been completed and was still in progress. Hospital discharge instructions, dated 3/7/2025, indicated the following order: Insulin Lispro 100 units per milliliter Solution Sliding Scale subcutaneously as ordered as needed for serum glucose, see parameters: 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-400 give 9 units; Above 400 give 10 units. A Physician's Order, dated 3/7/2025 and discontinued 3/7/2025 by a pharmacy interchange order, indicated the following order was to be implemented for the interchange: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units;			

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	221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-400 give 9 units; Above 400 give 10 units. The Physician's Orders for Resident 331, from the pharmacy interchange order, was dated 3/10/2025 and indicated the following: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-399 give 9 units and notify MD if over 350; 400-500 give 10 units and notify MD. A review of the Medication administration record indicated Resident 331 received Lispro sliding scale insulin on the following dates between 3/7/2025 and 3/10/2025. -3/7/2025 at 4:30 P.M. -3/10/2025 at 7:30 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M. Resident 331 did not receive any sliding scale insulin on 3/8/2025 or on 3/9/2025. A Care Plan, initiated 3/10/2025, indicated Resident 331 had a diagnosis of diabetes mellitus type 2 with the risk of hypo/hyperglycemia. Interventions included, but were not limited to: administer medications and insulins per order.			

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	During an interview, on 3/14/2025 at 11:28 A.M., the Regional Director of Clinical Services indicated the pharmacy had issued a therapeutic interchange of the sliding scale insulin on 3/7/2025 and the sliding scale insulin order was not signed by the nursing department and implemented until 3/10/2025. She indicated Resident 331 had missed two days of the sliding scale insulin ordered. On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, "Guidelines for Physician Orders-Following Physician Orders," dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated ":... It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care... 4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received...." 3.1-37(a)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care Based on record review and interview, the facility failed to provide urostomy care and required urostomy supplies for 1 of 3 residents reviewed for urinary devices. (Resident B) Finding includes: A record review for Resident B was completed on 3/11/2025 at 10:19 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage	F 0691	F691¿ It is the policy of this facility to provide urostomy care and have required urostomy supplies.¿ ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ Resident B no longer resides in the facility.¿ ¿ How will	04/14/2025

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	2, anal fissure, other artificial openings of urinary tract and dementia. A Medicare 5-day Minimum Data Set (MDS) assessment, dated 2/15/2025, indicated Resident B's cognitive status was not able to be assessed and he had a urostomy. The medical record did not have any physician orders related to a urostomy or the care of the urostomy. An Internal Medicine History and Physical, provided by the hospital from the 2/9/2025 admission, indicated Resident B had a past medical history of a malignant neoplasm of the posterior wall of the urinary bladder and a cystectomy that occurred on 6/3/2019. An Admission/Re-Admission Screener Assessment, on 2/12/2025 at 5:00 P.M., indicated Resident B was continent of his bladder. A Bowel and Bladder Incontinence Screener Assessment, on 2/13/2025 at 9:06 P.M., indicated Resident B voided appropriately without incontinence. Daily Skilled Nursing Notes, from 2/14/2025 through 2/16/2025, indicated the following urinary descriptions: -2/14/2025 at 2:42 A.M., Urinary: Continent. -2/14/2025 at 10:18 A.M., Urinary: Continent/Incontinent. -2/16/2025 at 5:23 A.M., Urinary: Continent -2/16/2025 at 11:27 A.M., Urinary: Continent, Resident has a urostomy. A document titled, "I Would Like to Know ....", indicated a concern from family regarding, "		other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? ¿ The DON/Designee completed an audit of residents with a colostomy, urostomy, or ileostomy for availability of supplies on 3/14/2025. Any concerns were immediately addressed, and supplies ordered on 3/14/2025. Statement 6 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee in-serviced the ancillary supply person on ordering supplies and par levels to be maintained on 3/14/2025 The DON/Designee in-serviced nursing staff on obtaining physician orders for urostomy, colostomy and ileostomy care and providing care. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.¿ Statement 7 How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will audit new admissions, re-admissions, and current residents with a urostomy, colostomy and/or ileostomy for availability of supplies, physician orders for care and care provided	

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	...Urostomy bag leaked and he sat in urine all night, Facility should have the necessary supplies on hand for the resident. His significant other is bringing in supplies ...." A document titled, "Internal review of 'I Would Like to Know ....' Form [QA Tool]", dated 2/14/2025, indicated the following: "urostomy site and bag examined and a small amount of urine was on the chux pad (disposable, absorbent bed pad) under Resident B's back. A new bag and wafer were replaced by the Assistant Director of Nursing on 2/14/2025. The Marketing Director was to request urostomy supplies to be sent by the hospital for urostomy maintenance. When Resident B arrived, no urostomy supplies were sent to the facility. The family provided the needed urostomy supplies the following day. " A Customer Service Progress Note, on 2/14/2025 at 1:00 P.M., indicated a discussion of urostomy supplies was conducted with Resident B and his wife. The information from the urostomy supplies (bags and wafers) the wife provided was taken so the facility could order the supplies needed to take care of the urostomy. Resident B requested a larger urinary drainage bag for overnight use. Resident B's wife brought in a larger drainage bag and a small tubing adaptor. The nursing staff reinforced the urostomy wafer and there had been no more leaking reported. A Nursing Progress Note, on 2/14/2025 at 10:34 P.M., indicated Resident B's wife had reported a leak was present with Resident B's urostomy. An assessment was completed and Resident B was dry with no leak noted. Resident B's daughter was at the bedside and requested the urostomy bag be changed. The nurse indicated dinner was being served soon and the nurse would change the		per physician orders 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.¿¿¿Exhibit I If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿ ¿ No cited harm and very limited scope. No ileostomies in the facility at this time	

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	urostomy bag after dinner so Resident B could lay down. Resident B's wife was statisfied with the plan and reassured resident B's daughter. The urostomy bag was changed after dinner. A Social Service Note, on 2/15/2025 at 1:00 P.M., indicated the Social Service Director called the family to discuss the urostomy. The Social Service Director had been in the building and had discovered the urostomy had been replaced and was working properly. A General Progress Note, on 2/16/2025 at 10:00 A.M., indicated Resident B's daughter stated, "We are taking him home." A Care Plan, initiated on 2/14/2025 and revised on 2/14/2025, indicated Resident B had urinary incontinence related to physically or mentally unawareness of the need to void. The care plan, nor any other care plans, addressed Resident B's urostomy. During an interview, on 03/14/2025 at 10:02 A.M., the Director of Nursing indicated Resident B was admitted to the facility on a Thursday (2/13/2025). She indicated the Marketing Director was to request that the hospital send urostomy supplies or was to arrange for the family to bring supplies until the facility could order the needed supplies for the urostomy. She indicated the supplies did not come from the hospital nor was the family made aware of the need to bring urostomy supplies. She indicated Resident B's family complained of Resident B lying in urine and that the CNA working had been reluctant to provide urostomy care per Resident B's complaints. She indicated the Assistant Director of Nursing had checked Resident B on Friday (2/14/2025) morning for leakage from the urostomy bag and had			

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	applied a new urostomy bag. The facility had also brought in an indwelling catheter bag to connect to the urostomy bag, so the urostomy bag did not need to be drained every two hours. A policy was provided, on 3/11/2025 at 1:48 P.M., by the Director of Nursing. The policy titled, "Urostomy", indicated, " ...A urostomy is similar to a fecal ostomy, but it is an artificial opening for the urinary system and the passing of urine to the outside of the abdominal wall through an artificial created hole called a stoma ...A urostomy patient has no voluntary control of urine, and a pouch system must be used and emptied regularly. Many patients empty their urostomy bag every 2 to 4 hours ...the pouch should be emptied when it is 1/3 full. The pouch may also be attached to a drainage bag for overnight drainage ...." This citation relates to complaint IN00453772. 3.1-47(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to provide non-invasive mechanical ventilation equipment for 1 of 3 residents and failed to properly store respiratory treatment for 1 of 3 residents reviewed for respiratory services. (Resident 333 & 16) Findings include: 1. During an observation on 3/10/2025 at 10:02 A.M., Bi-Pap (bi-level positive airway pressure) equipment was observed in Resident 333's room on a table by the door of her room. When Resident 333 was questioned about the Bi-Pap	F 0695	It is the policy of this facility to properly store respiratory equipment supplies. All residents utilizing respiratory equipment/supplies had the potential to be affected. Residents 333 and 16 had their respiratory equipment orders reviewed and the CPAP and BiPAP systems were cleaned and placed in proper storage. Resident 333 no longer reside at the facility. ="" p=""> The Clinical IDT team reviews new	04/14/2025

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	equipment, she indicated she had been admitted to the facility a week ago and was not sure why she had the Bi-Pap equipment in her room. During an observation, on 3/11/2025 at 9:26 A.M., 3/12/2025 at 9:32 A.M. and 3/13/2025 at 9:12 A.M., Bi-Pap equipment was observed on a table by Resident 333's door in a plastic bag. A record review for Resident 333 was completed on 3/12/2025 at 9:33 A.M. Diagnoses included, but were not limited to: acute respiratory failure with hypoxia, rib fracture, panic disorder and emphysema. The Admission Minimum Data Set (MDS) assessment .had not been completed yet. A Physician's Order for Resident 333, dated 3/5/2025, indicated to apply the Bi-Pap mask as ordered while sleeping and remove while awake for sleep apnea. The order indicated an inspiratory positive airway pressure setting of 10 cm H2O (centimeters of water) and expiratory positive airway pressure setting of 6 cm H2O. There was no baseline care plan related to Resident 333's diagnosis of obstructive sleep apnea or the use of the Bi-Pap machine. During an interview, on 3/13/2025 at 9:12 A.M., Resident 333 indicated she had not worn the Bi-Pap mask since before admission to the facility. She indicated the Bi-Pap mask had not been offered to her for use. During an interview, on 3/14/2025 at 10:12 A.M., the Director of Nursing (DON) indicated Resident 333 should have been wearing her Bi-Pap equipment, unless she had declined. The DON		admission and new orders as a means of chart audit each weekday morning. Social Services are a part of the IDT team. Charts will be reviewed upon admission, change of condition, and care plan meetings to ensure orders are being followed by the MAR (medication administration record, and TAR (treatment administration record). This audit includes the use of special supplies and equipment as ordered and monitored by the MAR, TAR and care plan. This includes CPAP and BiPAP respiratory systems. The Clinical IDT members were inserviced on 3/14/2025 regarding this citation. The IDT members will query PCC documentation weekly as a means of completed tasks of the MAR and TAR. This is an ongoing task. The manager will also look for proper supply and equipment storage on daily Angel Rounds as assigned. All findings will be reported to the QAPI team. Any deficiency will be immediately addressed per policy. Exhibit D Desk Review requested	

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	indicated any declination of wearing the Bi-Pap would have been documented. There was no documentation regarding any refusals to wear the Bi-Pap in Resident 333's record. 2. During an observation, on 3/10/2025 at 10:50 A.M., 3/12/2025 at 1:18 P.M., 3/13/2025 at 2:14 P.M. and 3/14/2025 at 9:34 P.M., Resident 16's C-Pap (continuous positive airway pressure) mask was stored uncovered in the top drawer of her bedside table. A record review for Resident 16 was completed on 3/12/2025 at 1:15 P.M. Diagnoses included, but were not limited to: Parkinson's disease, shortness of breath and obstructive sleep apnea. A Quarterly MDS assessment, dated 2/25/2025, indicated Resident 16 was cognitively intact and used non-invasive mechanical ventilation (C-Pap). A Physician's Order, dated 8/16/2024, indicated Resident 16 to wear the C-Pap at bedtime and during naps for sleep apnea. A Care Plan initiated, on 5/13/2024, indicated Resident 16 was at risk for altered sleep/respiratory function related to obstructive sleep apnea. During an interview, on 3/14/2025 at 10:13 A.M., the DON indicated the C-Pap mask should have been stored in a dated respiratory bag when the mask was not in use. A policy was provided, on 3/14/2025 at 1:00 P.M., by the DON. The policy titled, "Bi-Level Therapy", indicated, " ...Bi-level therapy is used			

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	to treat patients with obstructive sleep apnea who have difficulty tolerating CPAP. The goals of this therapy include: improved ventilation, improve quality of sleep, decrease hospitalizations, improve cognitive function, improve oxygen saturations during sleep, decrease work of breathing, and improve lung compliance. BiLevel machines are set with two pressures, Inspiratory and Expiratory ...." A policy was provided, on 3/14/2025 at 1:00 P.M., by the DON. The policy titled, "CPAP Therapy", indicated, " ...Continuous Positive Airway Pressure is used to treat obstructive sleep apnea. The goals of this therapy include; improve ventilation, improve quality of sleep, decrease hospitalizations, improve cognitive function, improve oxygen saturation during sleep, decrease work of breathing, and improve lung compliance ...." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on record review and interview the facility failed to assess a dialysis fistula for 1 of 2 residents reviewed for dialysis. (Resident 24) Findings include: A record review for Resident 24 was completed on 3/12/2025 at 9:43 A.M. Diagnoses included but were not limited to: chronic kidney disease stage 4 and fistula left wrist. A current care plan indicated Resident 24 was at risk for the dialysis fistula to become non-functioning. The interventions included but	F 0698	It is the policy of this facility to ensure residents who require dialysis services are consistent with standards of practice.¿ ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ Resident #24 no longer resides in the facility.¿¿ ¿ How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be	04/14/2025

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	were not limited to: "all fistulas will be assessed every shift and as needed for the bruit and thrill, if absent notify the doctor." The record for Resident 24, did not include a Physician's Order to assess the fistula. During an interview on 3/12/2025 at 2:34 P.M., Regional Nurse indicated the fistula should have been assessed and documented every shift. During an interview on 3/12/2025 at 2:39 P.M., LPM 6 indicated there was not an order for facility staff to assess the fistula and there was no documentation staff had been assessing the fistula. A current facility policy was provided by the Regional Nurse, on 3/13/2025 at 3:35 P.M. The policy titled, "Guidelines for Post Hemodialysis Care", indicated "... a licensed nurse should palpate the fistula daily for bruit/thrill and each shift the site should be assessed. 3.1-37(a)		taken?¿ The facility currently does not have any other residents receiving dialysis services.¿ ¿ What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee in-serviced the nursing staff on monitoring of dialysis resident fistula, thrill and bruit and the policy Guidelines for Post Hemodialysis Care" on 4/1/2025. Additionally, any staff member that fails to comply with the points of the in-service will be further educated and/or disciplined as indicated.¿ Exhibit V 1-7 ¿ How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will audit residents TAR 5 times a week x 4 weeks for monitoring of fistula, thrill and bruit, then 3 times a week x 4 weeks, then once a week x 4 months.¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until	

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			resolution.¿¿Exhibit E 1-2 Desk Review as no harm cited and no residents with fistulas at the facility.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to attempt a gradual dose reduction (GDR) for a resident's whose last GDR was completed on 11/17/2023, for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Finding includes: The record for Resident 22 was reviewed on 3/12/2025 at 1:32 P.M. Diagnoses included, but were not limited to Alzheimer's disease, anxiety, mood disorder and hypertension. Current Physician Orders, dated 11/17/2023, included Ativan (Lorazepam) an (antianxiety) 0.5 mg (milligrams) 1 tablet two times a day for anxiety. A current Care Plan, initiated on 1/18/2021 and revised on 11/17/2023, indicated Resident 61 "expresses/or exhibits restlessness, and nervousness and has a diagnosis of dementia." Interventions included, but were not limited to: monitor quarterly for Medication GDR for psychoactive medication through pharmacy consultant. A current Care Plan, initiated on 4/11/2022 and revised on 2/1/2023, indicated the resident displayed mood issues as exhibited by: excessive nervousness, restlessness, slapping at staff or	F 0758	It is the policy of this facility to attempt a gradual dose for residents that on receiving psychotropic medications. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee assessed resident #22 and no negative outcome related to the cited practice was found. A dose reduction was made on 3/31/2025. Statement 9 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The DON/Designee completed a 30 day look back of the pharmacy gradual dose reduction recommendations and concerns were immediately addressed. Statement 9 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Social Service staff were educated on GDR process. Exhibit U How be monitored to ensure the deficient practice will not recur, i.e. what	04/14/2025

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	yelling at staff during care. Interventions included, but were not limited to: Administer antianxiety medication as ordered. Monitor quarterly for Medication GDR for psychoactive medication through pharmacy consultant and psych services. A Consultant Pharmacy Note, dated 2/22/2025 at 2:31 P.M., indicated a Medical Record Review (MRR) was completed - Recommendation Made. "Please route recommendation to appropriate prescriber: due for GDR for the following medications: Lorazepam 0.5 mg BID Due for GDR attempt. Recommend the following options: 1). condition stable - Will attempt dose reduction of the following: Lorazepam 0.5 mg in AM and 0.25 mg in PM for anxiety. 2). Another agent to GDR- please describe below." All areas of the Pharmacy Recommendation were blank and had no response from the NP. A Psychotropic Medication Note To Physician/Prescriber, dated 2/22/2025, indicated "As a reminder, Per CMS Guidelines, this patient is due for a GDR for the following medication(s) to ensure that he/she is using the lowest possible effective/optimal dose. Lorazepam 0.5 mg BID (twice a day) due for GDR attempt." A Nurse Practitioner Progress Note, dated 3/10/2025, indicated "recent medication adjustments have improved her behavior, reducing her anxiety and disturbances in the pod. Is currently on Ativan (Lorazepam) 0.5 mg BID for anxiety, which has effectively decreased episodes of screaming, crying and other behaviors. Med changes since last visit: none documented." There was no indicatation the Nurse Practioner had considered the Pharmacist's recommendation to attempt a Gradual Dose reduction and no		quality assurance program will be put into place? The DON/Designee will audit pharmacy gradual dose reduction recommendations for appropriate documentation and/or follow up with recommendations monthly x 6 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. Exhibit F Desk Review requested secondary to no harm and one resident in scope.	

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	documentation the reduction attempt was contra-indicated. During an interview, on 3/12/2025 at 2:06 P.M., CNA 5 indicated the resident had behaviors where she would get mad if 2 staff went in to transfer her. She would get mad at the one who was doing the care and would not be mad at the other one who was there. CNA 5 indicated Resident 61 had gotten anxious when the facility had tried to change her where she would pull away. During an interview, on 3/14/2025 at 1:00 P.M., the Regional Nurse indicated the behaviors were documented on the Medication Administration Record (MAR) and in the nurses notes. The last documented behaviors/anxiety issues for Resident 22 included: Nursing Progress Note, on 10/14/2024 at 4:28 A.M., indicated the resident resisted care during the night. CNA's had attempted to change resident but she kept on resisting. Nursing Progress Note, on 10/14/2024 at 4:28 A.M., indicated the resident had been combative with night care- hitting, pinching, with 2 caregivers assisting with her care. During an interview, on 3/14/2025 at 1:05 P.M., the Director of Nursing indicated she did not see any indication for the antianxiety medication to be decreased. On 3/13/2025 at 1:45 P.M., the Director of Nursing provided the policy titled, " Guidelines for use of Unnecessary Drugs to Include Chemical Restraints", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Intent: It is the intent of this facility to ensure that any use of unnecessary meds, to			

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	include unnecessary psychoactive medications is prohibited... When a medication is indicated to treat a medical symptom- the facility must use the least restrictive alternative; for the least amount of time; provide ongoing re-evaluation of the need to the medication... Each resident's drug regimen must be free of unnecessary drugs. An " unnecessary drug" is defined as one that is used in excessive dose or duration, without adequate monitoring, without adequate indications for use... Residents who use psychotropic drugs will receive gradual dose reductions...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately, had resident labels, and medication carts were were free of loose pills for 2 of 3 medication carts observed. (Peach Pod & Maple Pod) Findings include: 1. During a medication storage observation, on 3/14/2025 at 10:44 A.M., with LPN 4 on the Peach medication cart, the following was observed: - An opened and undated bottled of Zinc Caps and Vit. C with no resident identifiers - An opened and undated vial of Lantus insulin. - An opened and undated Lispro insulin pen. - An opened and undated vial of Lantus insulin. - An opened bottle of betadine for a discharged resident. - A tube of neopsporin ointment with no resident identifiers. - An opened and undated bottle of ammonium	F 0761	It is the policy of this facility to ensure medications are stored appropriately, have resident labels and medication carts are free of loose pills.¿¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ The DON/Designee removed medications with no resident identifiers, disposed of undated insulin vials/pen, loose pills, expired assure prism solution, expired medications and lotions on Peach Pod and Maple Pod medication carts on 03/13/2025.¿Statement 10 ¿ How will other residents having the potential to be affected by the same deficient practice be identified and what corrective	04/14/2025

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	lactate lotion with the resident label torn off. - One (1) loose white pill. - Four (4) opened and undated containers of Mira lax. - An opened and undated bottle of Tussin cough syrup. During an interview, on 3/14/2025 at 10:57 A.M., LPN 4 indicated the medications should have been label and dated when opened. 2. During a medication storage observation, on 3/14/2025 at 10:59 A.M., with RN 13 on the ICF Maple medication cart, the following was observed: - An unlabeled Flutisone Propionate inhaler. - An unopened bottle of timolol eye drops with no resident identifiers. - An opened and undated vial of Humalog insulin. - Two (2) boxes of assure prism solution that had expired on 10/3/2023 and 12/10/2023. - Two (2) containers of Aquaphor (skin lotion) for a resident who had been expired and 1 container with no label. - An opened and undated bottle of maxi Tussin cough syrup. - Four (4) opened and undated bottles of Miralax. During an interview, on 3/14/2025 at 11:09 A.M., RN 13 indicated the medications should have been labeled and dated when opened. On 3/14/2025 at 1:45 P.M., the Director of Nursing provided the policy titled, "Medication Storage in the Facility", dated July 2024, and indicated the policy was the one currently used by the facility. The policy indicated "... Medications and biological's are stored safely, securely, and properly following manufacture or supplier recommendations... 14. Outdated, contaminated,		action will be taken?¿ No resident negative outcomes were reported through this period. ¿ What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee in-serviced the nurse and qualified medication assistances on dating medications when opened, not removing labeling, disposing of expired and discharged residents' medications and treatments, disposing of loose pills in medication carts on 3/14/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.¿Exhibit La & Lb ¿ How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will audit 5 random medication/treatment carts for unlabeled, undated, expired medications and treatment supplies and loose pills weekly x 4 weeks, then 3 random medication/treatment carts weekly x 4 weeks, then 3 random medication/treatment carts a month x 4 months.¿¿Exhibit Ga ¿ ¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI	

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	or deteriorated drugs and those in containers...will be immediately withdrawn from stock by the facility. 15. Medication storage areas are kept clean...." A policy for dating and labeling medications was requested, but were not provided prior to the survey exit. 3.1-25(j) 3.1-25(o)		meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿ Desk Review requested secondary to no harm cited and scope limitation.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on record review and interview, the facility failed to obtain a physician ordered lab for 1 of 1 residents reviewed for laboratory services. (Resident 61) Finding includes: The record for Resident 61 was reviewed on 3/12/2025 at 10:15 A.M. Diagnoses included, but were not limited to epilepsy, depression, hypertension, atrial fibrillation, hernia and cardiomegaly. A Nursing Progress Note, dated 2/8/2025 at 11:10 P.M., indicated the resident complained of abdominal pain where a hernia was protruding. The Nurse Practitioner was notified and an order to send the resident to the hospital was received. Resident 61 was hospitalized from 2/8/2025 to 2/13/2025. The Post Acute Transfer Order sheet, date 2/13/2025, indicated Resident 61 was to have	F 0770	F770 It is the policy of this facility to obtain physician orders for labs.¿ ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ Resident #61 had a Renal Panel scheduled for 04/02/2025 however, the resident again refused the blood draw. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?¿ ¿ The DON/Designee completed a 30 day look back of new admissions, re-admissions and physician orders for laboratory orders on 04/02/2025. Any concerns were immediately addressed, and labs completed on 04/02/2025.¿ Statement 11 What measures will	04/14/2025

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	laboratory draws (blood draws) consisting of CBC (complete blood count) and a Renal Panel test in 1 week. There was no documentation of the laboratory blood draws being completed and/or the results. During an interview, on 3/12/2025 at 11:50 A.M., the Director of Nursing indicated the lab orders should have been completed. 3.1-49(a)		be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The DON/Designee in-serviced the nursing staff on ordering labs per hospital discharge and per physician orders on 03/14/2025. Additionally, any staff member that fails to comply with the points of the in-service will be further educated or disciplined as indicated.¿Exhibit Ma & Mb ¿ How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will audit physician orders, new admissions and re-admissions for lab orders 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the commi04/02/2025ttee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿Exhibit B Desk Review secondary to no harm cited and limited scope	

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F 0803 Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on observation and interview, the facility failed to ensure recipes were followed when preparing pureed meals. This deficient practice had the opportunity to affect 4 of 4 residents who received pureed meals from the kitchen. Finding includes: During an observation of the preparation of pureed meals on 3/10/2025 at 11:41 A.M., Cook 2 added 4 scoops of cauliflower and an unmeasured amount of water to the mixer. She indicated she used a #8 (1/2 cup) scoop for the cauliflower and added as much water as she needed to get the correct consistency. Cook 2 did not use a recipe for the pureed cauliflower. During an observation of the main dining on 3/10/2025 at 12:29 P.M., Resident 14 received a pureed meal. The resident's pureed meal was watery in appearance and all of the individual food items ran together. During an observation of the preparation pureed meals on 3/13/2025 at 11:06 A.M., Cook 2 indicated she was preparing nine servings of mixed vegetables. Cook 2 added the vegetables to the mixer with an unknown measured amount of water and began mixing. Cook 2 added more water to the mixer and continued mixing. Cook 2 did not use a recipe to make the mixed vegetables. The pureed vegetables appeared very thin. She indicated she would add some thickener to the mixture prior to serving if the mixed vegetables appeared too thin after placing onto the steam table.	F 0803	F803¿ It is the policy of this facility to ensure recipes are followed when preparing pureed meals.¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ No Residents were identified to be affected by the cited practice.¿ 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 have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility.¿ Statement 12 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?¿ ¿ The Dietary Manager in-serviced the cooks on following recipes for mechanically altered diets including pureed foods on. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.¿Exhibit N 1-3 ¿ How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be	04/14/2025

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	During an interview on 3/13/2025 at 11:16 A.M., Cook 2 indicated she should have used a recipe when preparing the pureed meals. On 3/13/2025 at 2:05 P.M., the DON provided a policy titled, "Pureed Diet," date 6/2023 and indicated it was the policy currently being used by the facility. The policy indicated "...Foods are thickened if necessary to achieve a pudding or mashed potato consistency using commercial food thickeners or food items like mashed potato flakes. At times, it may be necessary to add liquid instead of thickening the food. Liquids used include: gravies, broth, juices or milk. Water is not used since it causes flavor loss then resulting in poor intake. Food characteristics: Can be piped, layered, or molded; appears softly formed on the plate. Shows some very slow movement under gravity but cannot be poured. Falls off spoon in single spoonful when tilted and continues to hold shape on plate...." 1.3-20(i)(1)		put into place?¿ ¿ The Dietary Manager will observe 10 random meal preparations for the cook following the recipe for pureed/mechanically altered diets weeks x 4 weeks, then 5 random meal preparations weekly x 4 weeks, then 3 random meal preparations monthly x 4 months.¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿Exhibit Oa, Ob, & Oc Desk review secondary to no harm	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This issue had the potential to affect 83 of 83 residents who received food from this kitchen. Findings include: On 3/10/202 at 9:39 A.M., a kitchen tour was conducted with Cook 2. The following was	F 0812	It is the policy of this facility to ensure to store food in a sanitary condition.¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ The DON/Designee assessed all residents on 3/14/20265. No negative outcome related to the cited practice.¿¿Statement 12 ¿ The Dietary	04/14/2025

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	observed in the walk-in cooler: - An opened bag of sausage gravy with a use by date of 3/1/2025. - An opened container of ketchup with no use by date. - An opened bag of tomato soup with a use by date of 2/28/2025. - An opened bag of lettuce not sealed tightly. - An opened bag of shredded cheddar cheese not sealed tightly. - An opened bag of lettuce with a use by date of 2/20/2025. - An opened box of hot dogs not sealed tightly. The following was observed in the walk-in freezer: - An opened bag beef of patties not sealed tightly. - An opened bag of green beans not sealed tightly. During an interview on 03/10/2025 at 9:51 A.M., Cook 2 indicated the bags that were not sealed tightly should have been and the expired foods should have been thrown out. On 3/12/2025 at 12:00 P.M., the Regional Director of Clinical Services provided a policy titled, "Food Safety and Sanitation," dated 4/2017 and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The facility will show safe food handling and storage of dry foods and supplies. Opened products will be labeled and stored in tightly covered containers. Foods in the refrigerator will be covered, labeled, and dated. Foods will be used by its use by date, frozen or discarded...." 3.1-21(i)(3)		Manager/Designee disposed of the sausage gravy, ketchup, tomato soup, lettuce, shredded cheese, hotdogs bag of beef patties and green beans from the freezer and walk-in cooler on 3/10/2025.¿ ¿ How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?¿ The ADM/Designee in-serviced the Dietary Manager on the policy “Food Safety and Sanitation” on 3/14/2025. The Dietary Manager in- the dietary staff on food storge and the policy “Food Safety and Sanitation” on 3/14/2025. Additionally, any staff fails to comply with the points of this in-service will be further educated and/or disciplined as needed.¿Statement 13, Exhibit P 1-3, Exhibit T 1-4 How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The Dietary Manager will audit the walk in cooler and freezer for foods to be properly stored 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any	

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			patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿ Desk Review secondary to no harm.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure staff members followed general infection control practices regarding enhanced barrier precautions (EBP) (CNA 10 & DON) and failed to ensure an infection prevention and control program was established and maintained. Findings included: 1. During an observation on 3/11/2025 at 9:27 A.M., CNA 10 was observed in Resident 14's room without wearing a gown. There was an EBP sign on the resident's door. During an interview on 3/11/2025 at 9:33 A.M., CNA 10 indicated she was gathering the residents trash and making the resident's bed. She indicated she should have had on a gown while in the resident's room. 2. During an observation on 3/12/2025 at 1:44 P.M., the DON was observed walking into a residents room who was on EBP precautions without wearing a gown. There was an EBP sign on the resident's door. During an interview on 3/13/2025 at 1:48 P.M., the	F 0880	F880 It is the policy of this facility to ensure staff members follow general infection control practices regarding enhanced barrier precautions and to ensure an infection prevention and control program is established and maintained.¿ ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ¿ On 3/14/2025, DON/Designee assessed resident #14, #17 and #3 and no negative outcome related to the alleged cited practice. The DON/Designee placed an EBP sign on resident #3's door on 3/14/2025.¿ How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?¿ The DON/Designee completed an audit of residents to determine EBP and contact isolation status and signs placed on doors as needed on	04/14/2025

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	DON indicated she went into the resident's room to help the resident off the toilet. She indicated she also provided perineal care prior to placing the resident in bed. She indicated she was wearing gloves but was not wearing a gown while providing care to the resident. She indicated she should have been wearing a gown.3. During an observation, on 3/10/2025 at 3:05 P.M., CNA 3 was observed providing toileting assistance for Resident 3, who had multiple skin tears. CNA 3 donned (applied) gloves but did not don a gown. Resident 3's room door did not have a Enhanced Barrier Precautions (EBP) sign on the door. During an interview, on 3/10/2025 at 3:15 P.M., CNA 3 indicated she was aware of Resident 3's multiple skin tears, but she did not know Resident 3 was on Enhanced Barrier Precautions. The record for Resident 3 was reviewed on 3/11/2025 at 9:15 A.M. A current Physician's Order, dated 8/3/24, indicated Enhanced Barrier Precautions due to skin tears. During an interview on 3/11/25 9:30 A.M., Nurse 9 indicated she thought the resident had a sign on her door due to her skin tears. Per Centers for Disease Control (CDC), the EBP sign directs providers and staff to gown and wear gloves during high-contact care, including toileting and transfering of residents with skin wounds that require dressings. 4. A record review for Resident 17 was completed on 3/11/2025 at 1:26 P.M. Diagnoses included but were not limited to: Chronic Hepatitis C, carrier of carbapenum resistant Acinetobacter baumannii (CRAB), and chronic kidney disease stage 3.		3/14/2025.¿Statement 14 The DON/Designee completed a look back to December 2024 and updated the infection control log and tracking and trending completed on 3/14/2025.¿Statement 14 All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility.¿ How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? ¿ The Regional Nurse Consultant in-serviced the DON and IP nurse on tracking and trending infections and logging infections monthly and the policy “Guidelines for Infection Prevention and Control” on 3/14/2025.¿ ¿Exhibit Q The DON/Designee in-staff on Enhance Barrier Precautions and Contact Isolation and PPE to be worn in rooms and the policy “Guidelines for Infection Prevention and Control” on 3/14/2025.¿Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.¿Exhibit R1-5 How be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?¿ ¿ The DON/Designee will observe 10 random staff members	

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	Physician Orders dated 1/19/2024 indicated Resident 17 was on contact precautions. A current Care Plan for Resident 17 indicated he was on contact precautions related to CRAB (a multidrug resistant infection). A sign was observed on Resident 17's door indicating staff were to apply gloves and gown before entering the room, were to perform all care while wearing gloves and gown, and dispose of linen and trash in designated receptacles. During an observation on 3/10/2025 at 10:25 A.M., a housekeeper was observed in Resident 17's room carrying a trash bag but not wearing gloves or a gown. During an observation on 3/10/2025 at 10:33 A.M., a CNA was observed making Resident 17's bed without wearing gloves or a gown. During an observation on 3/12/2025 at 9:05 A.M., a CNA was observed entering Resident 17's room without wearing gloves or a gown. During an interview on 3/11/2025 at 2:03 P.M., CNA 11 indicated that staff should have worn a gown and gloves when entering Resident 17's room. CNA 11 also indicated she should have been wearing a gown and gloves when she was making his bed. 5. On 3/14/2025 at 1:06 P.M., a review of the infection log book indicated the last documentation for tracking and trending resident infections had been completed in December 2024. The book lacked the documentation to show resident infections had been monitored since December 2024. During an interview, on 3/14/2025 at 1:10 P.M., the		entering EBP/Contact Isolation rooms for appropriately PPE weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members monthly x 4 months.¿ The DON/Designee will monitor the Tracking and Trending and logging of infections weekly x 8, then monthly x 4 months.¿¿¿ If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿¿Exhibit S Desk Review secondary to no harm cited and limited scope.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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
	Director of Nursing indicated the policies were reviewed annually and there had been tracking and trending done in 12/2024. She indicated there was nothing documented more recently for this year, and it should have been done. On 3/13/2025 at 2:35 P.M., the Regional Nurse provided the policy titled, "Guidelines for Enhanced Barrier Precautions: An extension of Personal Protective Equipment, "dated 12/2022 and indicated it was the policy currently being used by the facility. The policy indicated " ... Policy: It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multi-drug resistant Organisms also known as MDRO's ...." On 3/14/2025 at 1:45 P.M., the Director of Nursing provided the policy titled, "Guidelines for Infection Prevention and Control, " dated 8/17/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... Surveillance: A surveillance system designed to do the following will be maintained: Identify possible communicable diseases or infections before they can spread to other persons in the facility. Ensure that any communicable diseased are identified and reported timely and to the required parties/agencies. Ensure that standard and transmission-based precautions are followed in an effort to prevent the spread of infection...." 3.1-18(a) 3.1-18(b)(1)			