STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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. This visit included the Investigation of Complaint IN00434626. Complaint IN00434626 - Federal/State deficiencies related to the allegations are cited at F677. Survey dates: July 15, 16, 17, and 18, 2024 Facility number: 000578 Provider number: 155627 AIM number: 100267810 Census Bed Type: SNF/NF: 24 Total: 24 Census Payor Type: Medicare: 3 Medicaid: 17 Other: 4 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 30, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 08/15/2024 Facility respectfully requests a desk review.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record	F 0677	**F677 (D)**	08/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kiri Burks	Administrator	08/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	review, the facility failed to provide assistance with eating for 1 of 1 reviewed for ADLs. (Resident B) Finding includes: During a dining observation, beginning on 7/16/24 at 11:57 a.m., Resident B had not eaten any of her lunch as of 12:41 p.m. Her eyes were closed, and she had a utensil in her hand. At 12:45 p.m., QMA 6 picked up the resident's spoon and offered the resident green beans. During an interview following the observation, QMA 6 indicated Resident B was able to feed herself, but had insomnia and fell asleep frequently during the day and required reminders to eat. QMA 6 first prompted her to eat at 12:45 p.m. During an observation, on 7/17/24 at 8:41 a.m., four residents were in the dining room. No staff were present. Resident B was talking incoherently and fidgeting with her glasses. She had eaten a few bites of eggs. Housekeeper 4 entered the dining room at 8:46 a.m. and indicated that at least one nursing staff was required to be in the dining room until all the residents were done eating. She indicated staff was instructed to leave Resident B in the dining room until she was done eating. "Eventually they will just take her tray." Nursing staff entered at 8:54 a.m. and escorted individual residents out of the dining room. Resident B was alone in the dining room, with a tray in front of her from 8:55 a.m. until 8:58 a.m. During an interview on 7/17/24 at 2:55 p.m., Dining Staff 3 indicated Resident B had been in the dining room alone several times. A few weeks prior, Dining Staff 3 reported to work at 11:00 a.m.		**ADL Care provided for dependent residents.** It is the policy of the facility to ensure that residents who need assistance with their ADLs, including eating will be provided. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents will be provided the assistance needed to maintain their functional status, including assistance with eating meals. Resident B was assessed by the DON/Designee and no negative outcome related to the cited practice on 8.1.2024 **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All resident that requires assistance with meals has the potential to be affected by the cited practice, therefore, this plan of correction applies to those residents **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **The administrator/DON provided education to all**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	and Resident B was sitting in the dining room with her breakfast tray still in front of her. During an interview, on 7/18/24 at 2:50 p.m., QMA 6 indicated Resident B was left in the dining room after dinner unattended on more than one occasion. Staff knew they were not allowed to leave residents unattended in the dining room while they were still eating. Dinner routinely ended at 6:00 p.m. and Resident B was left alone in the dining room until 8:00 p.m. The resident was not routinely prompted to eat or assisted with meals. The resident frequently picked at her food and fell asleep. Resident B's medical record was reviewed on 7/18/24 at 12:03 p.m. Diagnoses included unspecified psychosis not due to a substance or known physiological condition; unspecified lack of coordination; unspecified insomnia; need for assistance with personal care; Alzheimer's disease; muscle wasting and atrophy of bilateral upper extremities, not elsewhere classified; generalized muscle weakness and lack of coordination. A quarterly Minimum Data Set (MDS) dated 6/18/24, indicated the resident had moderate cognitive impairment and required partial to moderate assistance to eat. Resident B's current care plan, dated 4/6/22, indicated the following: "ADLs (Activities of Daily Living) fluctuate and amount of assist required fluctuates ... "I need set-up/supervision assist with eating/drinking ...assist at meals with tray set-up and meals/eating as needed ...give verbal cues and encourage to eat as needed (interventions dated 11/5/19) ..."I am at risk for aspiration. History of CVA (cerebral vascular		**nursing staff in regard to the importance of Activities of daily living and feeding assistance. The DON/designee will monitor mealtimes to ensure staff are available in dining areas to assist residents with eating. Any staff who fails to comply with the points of these in-services will be further educated and/or disciplined accordingly.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** ="" p="">The Administrator/Director of Nursing/Designee will monitor at least 2 mealtimes 5x weekly for 4 weeks, and then 1 meal 5x weekly for 4 weeks, and then 1 meal 3x weekly for 4 weeks, to ensure staff are present and available to assist any resident needing feeding assistance. 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 be addressed, and action plan will be written by the QAPI committee and will be monitored by the Administrator weekly until resolved. **5 By what date the systemic changes for each deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	accident or stroke) in 2014; Swallowing difficulties; history of pocketing food, long history of choking on foods/spitting" ... monitor for coughing or choking with meals ...." A review of Resident B's documentation of her percentage of meals eaten, dated 6/19/24 through 7/18/24, indicated she consumed 0-25% of her food during 30 meals, 26-50% of her food during 18 meals, 51-75% of her food during 30 meals, and more than 76% of her meals during 9 of a total of 88 meals consumed. She refused one meal. Resident B's Self Performance for eating evaluation, for the same dates, indicated at a minimum, she required supervision including oversight, encouragement or cueing for 82 of 88 meals. A current, undated policy, provided by the Director of Nursing (DON) on 7/18/24 at 5:05 p.m., titled "Mealtime Observation" indicated: " ...Guideline: Residents shall be observed during mealtimes to monitor ...intake of food and beverage items. Appropriate replacements/substitutions will be offered when needed. Procedure: 1. The dining room shall be monitored by the Dining Services Manager or designee at all mealtimes... 3. Nursing staff will be readily available during mealtimes, in the dining room ... 5. Substitutions shall be provided for all residents when poor food/fluid intake is noted ...." The Federal tag relates to Complaint IN00434626. 3.1-38(a)(2)(D)		**will be completed?** August 15, 2024	
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, record review, and interview, the facility failed to ensure staff information was posted in a prominent place, was readily accessible to residents and visitors, and was in a clear and readable format.	F 0732	**F732 (D)** **Posted Nurse Staffing Information** It is the policy of the facility to	08/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	Findings include: On 7/15/24, at 11:32 a.m., staffing information was not readily available at the nurses station towards the front doors of the facility. No information was available on the walls at the front of the facility. The front of the building was the main entrance into the facility. On 7/15/24, at 11:41, during an interview with the Administrator (Adm), she indicated the staff posting was on the wall outside of the Director of Nursing's (DON) door. The DON's office was located in the west hall of the facility, past the nurses desk, through a doorway, and on the left side of the hallway. On 7/16/24, at 12:05 p.m., nurse staffing was posted outside the DON's door. There were two plastic sleeves that contained two 8.5 x 11 sheets of paper with staffing information. The two documents were positioned on their sides. In order to view the documents, they had to be removed from the eye-level hooks where they were hung, and repositioned to an upright orientation in order to be read. The font was small, approximately a 10 or 12 font size. During an interview with the DON, on 7/18/24 at 12:39 p.m., she indicated she thought the posting location was fine. She had been instructed by the Administrator to move the postings to a publicly accessible location at the front of the facility. A document titled "Guidelines for BIPA Staffing Posting Requirement", revised on 7/24/23, and provided by the DON on 7/18/24 at 5:05 p.m., included the following information: "...4) Posting Requirements: a) Data must be posted in a clear,		post the nurse staffing data daily at the beginning of each shift. Data must be posted in a clear and readable format in a prominent place readily accessible to residents and visitors. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents who reside in the facility have the potential to be affected by this deficient practice. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **The administrator/designee in-services the director of nursing and scheduler on the policy "guidelines for BIPA staffing posting requirements" on July 25th, 2024. Any staff member who fails to comply with the points of the in-service will be further educated and/or disciplined accordingly. the administrator/DON/designee have moved the posting to a**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	readable format with a font of 14 or above. b) Data must be in a conspicuous prominent location, accessible to residents/visitors...."		**prominent location across from the administrator's office on July 18, 2024, and posting will remain there moving forward.** 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The administrator/DON/designee will audit the BIPA staffing posting and location 5x weekly for 4 weeks, then 3x weekly for 4weeks, then 1x weekly for 4 months. If the facility is within 95% compliance at the end of the 6 months monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will be addressed, and action plan written by the QAPI committee and monitored by the administrator weekly until resolved. 5. By what date systemic changes for each deficiency will be completed? August 15, 2024	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was attractive and palatable. (Residents 5, 15, 18, and 21) Findings include: During an interview on 7/15/24 at 11:08 a.m., Resident 18 indicated she was not feeling well. She thought her blood glucose might be low. She had not eaten any breakfast that morning because she "...could not face another peanut butter and jelly sandwich...." She described the food as "awful". She complained repeatedly to the administrator and other staff about the palatability of the food. She finally resorted to eating peanut butter and jelly sandwiches because that was the only thing she could tolerate. Carbohydrates were too many and there was not enough protein provided. The food was not properly seasoned and not appealing in appearance. During an interview on 7/18/24 at 10:42 a.m., Resident 5 indicated the food palatability varied. Sometimes the food was not bad, but other times it was not edible. It all depended on who was working in the kitchen. During an interview on 7/15/24 at 11:23 a.m., Resident 21 indicated the food was not good, sometimes not hot, and unappealing. During an interview on 07/15/24 at 3:12 p.m., Resident 15 indicated the food was sometimes bad... sometimes good, depending on who was working in the kitchen. Information gathered at a Resident Council	F 0804	**F804 (D)** **Nutritive Value/Appear, Palatable/Prefer Temp** It is the policy of the facility that the facility must provide each resident food prepared by methods that conserve nutritive value, flavor, and appearance; Food and drink that is palatable, attractive, and at a safe and appetizing temperature. **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents 5, 15, 18 and 21 were assessed by the DON on 8.1.2024, no negative outcome related to the cited practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**: All residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of this facility. The Dietary Manager/Designee completed a facility wide audit on all current residents to determine likes and dislikes and update the Tray Card system on 8.13.2024. An Alternate menu was implemented by the Dietary Manager/Designee. **3. What measures will be put in**	08/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	Meeting on 7/17/24 at 3:04 p.m. included the following: Resident 21 indicated improperly cooked shrimp had been served twice. Resident 15 indicated she would taste what was being served for eating breakfast - eggs were often cold and the oatmeal was too thick. During an observation of dining on 07/16/24 at 12:26 p.m. a resident was overheard saying the chicken was actually soft, that she could actually eat it. At 12:43 p.m., another resident was observed sending her hamburger back to the kitchen because it was cold. A test lunch tray was provided on 7/16/24 at 1:10 p.m. The menu for the day included Dijon chicken, rosemary roasted potatoes, green beans, and chocolate pudding. The chicken was appropriately cooked, was warm (not hot), and was seasoned slightly. There was no Dijon taste to the chicken. The rosemary roasted potatoes, light gray to dark gray in color, were grease soaked and mushy. They tasted like grease. The rosemary could be detected but there were no other seasonings. The green beans were from a can and no salt or any other seasoning had been added. They were flavorless and mushy. The chocolate pudding was lumpy and not thoroughly mixed. During an interview with the Administrator on 7/17/24 at 4:02 p.m., she indicated one resident complained frequently about too much pepper on the food. Another resident had complained about a curry soup. She was not aware of other residents complaining about the look and taste of the food. She did not encourage the kitchen staff to taste the food before serving it because she wanted to avoid cross-contamination.		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator educated the Dietary Manager and other dietary staff on August 1, 2024, on food temperature logs usage, safe food temperatures, and food palatability. Also encouraged the cooks to taste test the food accordingly before serving the residents in order to ensure palatability. The Administrator educated the facility staff on the Alternative Menu on 8/1/2024. Any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The “F804 - Nutritive Value/Appear, Palatable/Prefer Temp Audit” will be completed 5x weekly for 4 weeks, 3x weekly for 4 weeks, 1x weekly for 4 weeks, then monthly for 3 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 and any needed Action Plan will be written by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	No policy addressing food attractiveness or palatability was provided. 3.1-21 (a)(1)(2)		QAPI committee and monitored by the Administrator weekly until resolved. **5. By what date the systemic changes for each deficient will be completed.** August 15, 2024	
F 0809 SS=D Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.			
	Based on observation, interview, and record review, the facility failed to provide a nourishing snack at bedtime when there was more than fourteen (14) hours between the evening meal and breakfast the next day. This had the potential to affect twenty four (24) out of twenty four (24) residents. (Residents 3, 16, 15, 18, 21, and 22)	F 0809	**F809 (D)** **Frequency of Meals/Snacks at Bedtime** It is the policy of the facility to provide a nourishing snack at bedtime when there was more	08/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	Findings include: During a resident council meeting on 7/17/24 at 3:04 p.m., Resident 15 indicated the facility used to provide snacks in the evening. Eventually, the snacks provided were only "oatmeal pies". The night before the meeting, there were no snacks available at all. Resident 21 indicated the facility sometimes provided goldfish, oatmeal pies, or a sandwich. If the facility would run out of snacks, the residents did not get an evening snack. Resident 15 indicated residents would sometimes ask a kitchen staff member to hold food items for them. The staff member would do so. All residents present at the council meeting indicated snacks were not offered in the evenings. They could get snacks only when they asked for them and often, no snacks were available. During an interview with CNA 5 on 7/18/24 at 2:50 p.m. she indicated residents could get a snack at bedtime if they asked. The problem was there were no snacks to pass out to the residents. The residents used to get chips and cookies. Now, they could barely get cookies. She had, on occasion, gone to the grocery store to buy granola bars because there were no snacks available. The facility did not provide peanut butter crackers or even oatmeal cookies. They did sometimes have sandwichest, but those could be up to four (4) days old. The sandwiches were soggy and mushy. Most of the residents on the West hall wanted snacks. When they were available, snacks could be found in the therapy room refrigerator or cabinets. An untitled document, provided by the Business Office Manager (BOM), on 7/15/24 at 3:36 p.m., indicated mealtimes at the facility were as follows:		than 14 hours between the evening meals and breakfast the next day. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents' 3, 16, 15, 18, 21 and 22 were assessed by the DON/Designee on 8/1/2024 and no negative outcome related to the cited practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of this facility. 3. **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-service nursing staff on providing a nourishing snack at bedtime on 8/1/2024. Nursing staff will offer each individual resident a HS snack every evening. Nursing staff will indicate in their documentation whether**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	Breakfast - 7:30 a.m., Lunch - 12:00 p.m., and Dinner - 5:00 p.m. The time between dinner and breakfast the next day was fourteen and a half (14.5) hours. During an interview with the Administrator on 7/17/24 at 4:02 p.m., she indicated snacks were provided to the residents and kept in the refrigerator in the therapy room. Snacks were passed with medications at night. Residents could have a snack any time of day they wanted. In addition to sandwiches in the refrigerator, residents could have crackers and cookies. To tell a resident snacks were unavailable was not acceptable. No policy referencing evening or bedtime snacks was provided by the facility. 3.1-21(d) and (e)		**resident accepted the snack or refused. Any staff who fail to comply with the points of the in-services will be further educated and/or disciplined accordingly.** **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** ="" p=""> The DON/designee will audit HS snacks being offered 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then 1x weekly for 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. Any needed Action Plan will be written by the QAPI committee and monitored by the Administrator weekly until resolved. 5. **By what date the systemic changes for each deficiency will be completed?** 8/15/2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 5 residents reviewed for EBP (Resident 21) Findings include: Resident 21's clinical record was reviewed on 7/16/24 at 3:25 p.m. Diagnoses for the resident included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, morbid (severe) obesity due to excess calories, and non-pressure chronic ulcer of other part of left foot with unspecified severity.	F 0880	**F880 (D)** **Infection Prevention and Control** It is the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	08/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	Current physician orders included, but were not limited to: 6/7/24 - An external ointment, mupirocin 2%, was to be applied to the left great toe topically every day and night shift. The wound was to be covered with dry, sterile gauze. 5/14/24 - A weight bearing as tolerated (WBAT) surgical shoe to be worn on the left foot. 5/6/24 - Monitor the left great toe each shift for signs and symptoms of infection, dressing placement, and surrounding tissue until healed. 2/8/24 - Notify the physician of any foul-smelling odor, red streaking up the leg, discolored drainage, and watch for infection, every shift. During an observation, on 5/17/24 at 11:23 a.m., Resident 21 was in her room. She was wearing disposable booties over her socks. Drainage was observed on the disposable bootie. The resident indicated she had a diabetic ulcer on the bottom of her toe. She could see the drainage on the bootie. The room had no signage, inside or outside, to indicate the resident required EBP. No personal protective equipment (PPE) was available inside or outside the room. During an observation on 5/17/24, at 1:42 p.m., Resident 21 indicated the nurse had put on a new bootie but did not change the dressing. She indicated the nurses providing dressing changes to her foot did not wear gowns when providing care. During an observation on 7/16/24, at 9:30 a.m., the wound care nurse and the DON performed a		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Enhanced Barrier Precautions initiated for resident 21 on July 17,2024. Resident affected by the deficient practice has shown no adverse effects from the deficient practice as assessed by the DON on 7/17/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents residing in the facility have the potential to be affected by the cited practice, therefore this plan of correction applies to all residents in the facility. **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/IP/Designee completed an in-service with all staff on July 26, 2024, on Enhanced Barrier Precautions and proper PPE, hand hygiene, sign postings on door, physician orders related to EBP and notification. Additionally, any staff that fails to comply with the points of these in-services will be further educated and/or disciplined as indicated. **How the corrective action(s)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	dressing change on Resident 21's left great toe. The DON provided hands-on care while the wound care nurse measured the wound. Both nurses donned gloves before providing care. No gowns were donned before or during the procedure. The wound care nurse indicated the wound was a full-thickness, diabetic foot ulcer. During an interview with the corporate nurse consultant, on 7/17/24 at 11:15 a.m., she indicated EBP should be used for residents with catheters and wounds. She was not aware of any residents with wounds in the facility. She was not aware EBP was not being followed for Resident 21. PPE should be available in the resident's room. During an interview with the Director of Nursing (DON) on 7/18/24 at 12:38 p.m., she indicated Resident 21 should be on EBP. A document, titled "Guidelines for Enhanced Barrier Precautions (EBP) - An extension of Personal Protective Equipment (PPE)", with a revision date of 12/2022, was provided by the Administrator on 7/17/24 at 4:02 p.m. The document indicated it was the policy of the facility "to ensure that additional and appropriate PPE is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms, also known as MDROs. Enhanced Barrier Precautions (EBP) are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of a MDRO or a colonized MDRO. These precautions are generally in place for the duration of the resident's stay, or until there is a resolution		**will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DON/IP/Designee will monitor 5 residents 5 times weekly x 4 weeks for Enhanced Barrier Precaution needs/Implementation, then 5 residents 3 times weekly x 4 weeks, then 5 residents one-time weekly x 4 months. If the facility is within 95% compliance at the end of 4 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. **By what date the systemic changes for each deficiency will be completed?** August 15, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 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
	of the wound or discontinuation of the device that placed the resident at 'higher risk'...Examples of 'high contact' resident care activities at which time EBP is to be practiced are: a) dressing care/changes/management of dressings...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. 4) Ensure that all necessary supplies are available in an enclosed clean labeled container outside thee resident's room...." 3.1-18(a)			