STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wabash Skilled Nursing Facility East The	1900 N Alber St Wabash, IN 46992

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure a resident's wound prevention interventions were implemented and the care plan was updated for 1 of 3 residents reviewed for wounds. (Resident C)Findings include: The following was observed on 3/16/26: At 9:50 a.m., Resident C laid on his back on an air mattress with his head elevated, a foot cradle (to keep the weight of the bed covering off a resident's feet and legs) was positioned at the end of the bed. His feet were directly on the mattress. His blankets covered his left foot, and he had a nonskid sock on his right foot. At 12:16 p.m., he was lying on his back on an air mattress with his head elevated. The foot cradle was positioned at the end of the bed. His feet were directly on the mattress. His blankets covered his left foot, and he had a nonskid sock on his right foot.At 3:23 p.m., he was lying on his back on an air mattress with his head elevated. The foot cradle was positioned at the end of the bed. His feet were directly on the mattress. His blankets covered both feet.Resident C's clinical record was reviewed on 3/16/26 at 11:35 a.m. Diagnoses included permanent atrial fibrillation, pulmonary fibrosis, type II diabetes mellitus with diabetic neuropathy, unspecified diastolic (congestive) heart failure, chronic kidney disease, peripheral vascular disease, unspecified protein-calorie malnutrition, post-polio syndrome, and other chronic pain. His current physician orders included bilateral heels to be elevated off bed with pillows every shift for preventative (11/5/24), Aquaphor external ointment (skin protectant) apply to bilateral legs/feet topically every day and evening shift for prevention (12/2/25), Pro-heal (promotes healing) give 30 milliliters (ml) twice daily (3/5/26), encourage moon boots (for heel protection) at all times except for bathing and care every shift (3/5/26), right root second toe (distal) cleanse with povidone iodine (skin antiseptic), cover with povidone iodine soaked gauze, cover with abdominal pad, wrap with gauze and secure with tape every day shift (3/13/26), right foot third digit (proximal) cleanse with povidone iodine, povidone iodine-soaked gauze, abdominal pad, rolled gauze, and secure with tape every day shift (3/13/26), right great toe, cleanse with povidone iodine, cover with povidone iodine-soaked gauze, cover with abdominal pad, wrap with gauze and secure with tape every day shift (3/13/26).A 2/11/26, quarterly, Minimum Data Set (MDS) assessment indicated he was severely cognitively impaired. He was dependent for toileting, upper/lower body dressing, putting on/taking off footwear, personal hygiene, and rolling from back to left and right side, and return to lying on his back in bed. He was at risk for developing pressure ulcers. He had a pressure reducing device to his bed and chair. A quarterly Braden Scale assessment (for predicting pressure ulcers) dated 2/27/26 indicated he was at a moderate risk for the development of pressure ulcers. A nurses note, dated 3/4/26 at 4:05 p.m., indicated a CNA reported new areas were found to the resident's toes during a shower. His right great toe had two areas measuring each 1.8 centimeters (cm) length (L) x 1.0 cm width (W) and 1.0 cm (L) x 0.5 cm (W), respectively. His right foot third toe with two areas measuring 1.0 cm (L) x 0.8 cm (W) and 1.0 cm (L) x 1.0 cm (W). The areas were cleansed with wound cleanser, calcium alginate was applied, and bordered gauze.He had a current care plan, revised on 2/11/26, for increased risk for impaired skin integrity related to decreased mobility, incontinence, right hand contracture, chronic diarrhea, chronic cardiovascular disease, type II diabetes mellitus, at risk for malnutrition, peripheral vascular disease, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obesity, chronic kidney disease, he received an anticoagulant and an antiplatelet medication. Interventions included offload heels at all times while in bed and may use a pillow to ensure ankles and heels were floating (2/11/26), precautions for prevention of pressure ulcers would be completed: good peri care and drying of skin, apply protective barrier cream, reposition him frequently when in bed or chair and/or wheelchair, off load heels as needed, Certified Nurse Aide (CNA) shower/skin observations to be reported to the nurse for any unusual findings or changes in his skin integrity (2/11/26), and pressure reducing/relieving mattress per policy (2/11/26). He had care plans revised on 3/12/26 for an arterial/ischemic ulcer of the location: Right foot great toe, Right foot second toe distal, and Right Foot 3rd digit proximal related to: related to: Vascular insufficiency. Interventions initiated on 3/12/26 included inspect my feet daily, especially between the toes (3/12/26), keep the feet clean and dry (3/12/26), observe extremities for signs and symptoms or poor tissue perfusion (3/12/26), observe/document wound (3/12/26), observe/document/report as needed any signs or symptoms of infection (3/12/26), and weekly treatment documentation (3/12/26).During an interview on 3/16/26 at 12:28 p.m. QMA 5 indicated Resident C's wound prevention interventions included the foot cradle and moon boots while in bed.During an interview on 3/16/26 at 1:20 p.m. Resident C was observed lying on his back on an air mattress, his sheet and blanket were covering his left foot, and he had a nonskid sock on his right foot, and his feet were lying on the mattress. He indicated the facility was putting lotion and a sticker on his buttocks. He had problems with his right foot more than his left foot. He thought they did daily treatments to his right foot. He had pain in his feet and buttocks. At times they propped him on his side but seldom put pillows under his legs. He indicated that the foot cradle at the end of his bed was to keep the blankets from bothering his feet as he had his second toe amputated on his right foot. During an interview on 3/16/26 at 3:31 p.m. QMA 7 indicated Resident C's wound prevention interventions included moon boots at all times, wrapping his foot in gauze, the air mattress, and the foot cradle to keep the blankets off his feet and repositioning him every two hours. The moon boots were an intervention implemented in the last few weeks. During an interview on 3/17/26 at 11:45 a.m. the DON indicated Resident C's wound prevention interventions included moon boots, but he refused them at times, the foot cradle to keep his blankets elevated, off load his heels, reposition him, the air mattress and make sure his toes were nice and dry. He had multiple dopplers (ultrasound studies), he had a procedure at the vein clinic, and his second toe had been amputated. The MDS Coordinator was currently updating the care plans due to the corporation wanting to revise care plans. They normally updated interventions as a wound was discovered and as needed and remove old interventions if they were not appropriate. During an interview on 3/17/26 at 1:51 p.m. the ADON indicated she used to work in medical records and she would update the CNA sheets related to interventions. LPN 13 took over the Medical Records department and was getting acclimated to the position. The CNAs would go by the interventions on the CNA sheets, not the care plan in the resident's electronic health records. Review of CNA sheets at the time of the interview indicated, under the section Need to know, for Resident C included enhanced barrier isolation, left sided weakness, foot buddy to end of bed, diabetic, diabetic mechanical soft, thin liquids and Proheal per nurse.A current facility policy, titled Baseline Care Plan Assessment/Comprehensive Care Plans and provided by the Administrator on 3/17/26 at 12:51 p.m. indicated the following: Policy .The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs . Procedure .9 .The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues. 10. The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning /CQI meetings where in-depth review of the 24-Hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated as necessary This citation relates to Intake 2788978. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure Qualified Medication Aides (QMA) were completing wound treatments within their scope of practice for 1 of 3 residents reviewed for wounds. (QMA 5, 7, 9 and Resident D)Findings include:Resident D's clinical record was reviewed on 3/16/26 at12:09 p.m. Diagnoses included chronic systolic (congestive) heart failure, chronic pain syndrome, personal history of other venous thrombosis and embolism (blood clots), unspecified protein-calorie malnutrition, unspecified atherosclerosis of native arteries of extremities, bilateral legs, and restless legs syndrome. A Nurse Practitioner (NP) wound note, dated 12/30/25 at 10:08 a.m., indicated an original wound to the left second toe noted on 8/19/25 was resolved, but a new wound developed on the left great toe, initially presenting with purple discoloration concerning for an evolving arterial ulcer. Although vascular studies later showed adequate perfusion, the great toe wound progressed with intermittent redness, dryness, fluctuating exudate, and periods of the resident's refusal of recommended dressings. The wound was later classified as trauma-related and likely from a transfer incident. The wound had improved, dry, without drainage and was smaller in size measuring 0.8 centimeter (cm) x 1.2 cm x 0.1 cm (length x width x depth) with full thickness loss. The January 2026 Medication Administration Record (MAR) included orders to cleanse left great toe with povidone iodine (skin antiseptic) and leave open to air every day shift. Monitor for signs and symptoms of infection or worsening and contact nurse practitioner or physician. QMA 5 documented that she completed the treatment on 1/1/26and 1/6/26. A nurses note, dated 1/29/26 at 8:59 p.m., indicated he had a wound to his left toe that was recurring. The wound had reopened and was bleeding. The wound was wrapped with gauze, but resident would not allow a measurement of the wound. An NP wound note, dated 2/3/26 at 9:50 p.m., indicated his left great toe wound measured 0.7 cm x 1.0 cm x 0.1 cm (length x width x depth). The wound had reopened with partial thickness loss. The February 2026 MAR included orders to cleanse left great toe with povidone iodine and leave open to air until resolved every day and evening shift. QMA 7 documented in the MAR that she completed the treatment on 2/3/26. The February 2026 MAR included cleanse left great toe with povidone iodine, paint with povidone iodine and leave open to air every day and evening shift. Monitor for signs and symptoms of infection or worsening and contact nurse practitioner or physician with any concerns. QMA 5 documented in the MAR that she completed the treatment on 2/11/26, 2/16/26, 2/17/26 and 2/25/26. QMA 7 documented that she completed the treatment on 2/10/26. QMA 9 documented that she completed the treatment on 2/11/26, 2/14/26, 2/15/26, 2/16/26, 2/18/26, 2/19/26 and 2/25/26. A NP wound note dated 2/24/26 at 10:30 p.m. indicated the left great toe wound measured 0.6 cm x 0.7 cm x 0.1 cm (length x width x depth). The wound was stable with partial thickness loss, and scabbed. The March 2026 MAR included cleanse left great toe with povidone iodine, paint with povidone iodine and leave open to air every day and evening shift. Monitor for signs and symptoms of infection or worsening and contact nurse practitioner or physician with any concerns. QMA 5 documented in the MAR that she completed the treatment on 3/1/26 and 3/12/26. QMA 7 documented that she completed the treatment on 3/6/26, 3/7/26, 3/8/26, 3/10/26, 3/12/26 and 3/13/26. QMA 9 documented that she completed the treatment on 3/1/26, 3/2/26, 3/5/26, 3/11/26 and 3/15/26. During an interview on 3/16/26 at 12:28 p.m. QMA 5 indicated a QMA was allowed to apply creams and powders to residents, but was not allowed to treat any stage 1 (intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area) or higher wounds. It was possible that she signed that she completed Resident D's wound treatments, but the wound had worsened and the QMAs stopped doing the treatment.During an interview on 3/16/26 at 3:31 p.m. QMA 9 indicated a QMA was allowed to apply creams and powders to residents, but nothing over a stage 1 wound or any wound that was open. She had watched the nurse complete Resident D's wound treatment, and she would sign them off in the MAR. She had not completed the (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment herself but thought she could apply povidone iodine to a wound. During an interview on 3/17/26 at 10:17 a.m. QMA 7 indicated a QMA was not allowed complete treatments above a stage 1, basically if the wound was open, she did not touch it. She was allowed to apply powders and creams to residents. She had not completed Resident 9's wound treatments as he had a crater on top of his toe. During an interview on 3/17/26 at 11:45 a.m. the DON indicated QMAs could not complete wound treatments above stage 2 (intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.), wounds with bandages, or invasive treatments. She thought the QMAs could complete Resident D's wound treatments as his toe was left open to air and the nurse could assess the wound at any time. The facility's QMA job description, provided by the Administrator on 3/17/26 at 2:03 p.m., indicated the following: Position Summary .The person holding this position is delegated the responsibility for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures. Essential job functions .2. QMAs are not allowed to do any of the following .Any other invasive treatments as ordered The Qualified Medication Aide Scope of Practice was retrieved from the from the Indiana Department of Health (IDOH) website at https://www.in.gov/isdh/files/QMAScopeofPractice on 3/17/26 at 12:30 p.m. and indicated the following: .The following tasks are within the scope of practice for the QMA unless prohibited by facility policy . (3) .The QMA shall document in a resident's clinical record all medications that the QMA personally administered. The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all .(12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis, fungal-infection, psoriasis, eczema, first degree burn, stage one decubitus ulcer .The following tasks shall NOT be included in the QMA scope of practice . (6) Administer a treatment that involves advanced skin conditions, including stage II, III, and IV decubitus ulcers This citation relates to Intake 2788978. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(2)