Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER: Waters of Huntington Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 Grant St Huntington, IN 46750	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on interview and record review the facility failed to ensure assessments were completed for 3 of 4 residents reviewed with respiratory illness and falls. (Resident J, Resident C and Resident D). Findings include: 1.) Resident J's record was reviewed on 3/4/25 at 12:24 PM. Diagnoses included chronic obstructive pulmonary disease (COPD), anemia and hypertension. A review of Resident J's current quarterly Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). Resident J declined an interview. A review of Resident J's current care plan titled chronic respiratory illness indicated the resident had a problem of asthma, with a goal date of 5/7/25. Interventions included observing for shortness of breath, cough, increased secretions and notifying the physician when necessary. A review of physician orders dated 2/25/25, indicated prednisone 40 mg was ordered to be given for 4 days, then reduced to 20 mg for 3 days, then 10 mg for 3 days for an upper respiratory infection with wheezing. A review of progress notes, dated 2/14/25 at 7:00 PM, indicated Resident J had a cough and clear breath sounds. Progress notes, dated 2/18/25 at 7:30 PM, indicated Resident J was seen by Nurse Practitioner 8 for a harsh cough with dark, yellow sputum production. The note indicated Resident J had reported symptoms started at the end of the previous week. The Nurse Practitioner indicated Resident J had acute bronchitis and prescribed Augmentin (antibiotic) and prednisone (steroid). Progress note,s dated 2/25/25 at 7:36 PM, indicated Resident J had continued respiratory symptoms, including respiratory wheezes. The Nurse Practitioner recommended completing her course of antibiotics, steroids, and breathing treatments would be increased in frequency. A review of progress notes between 2/14/25 to 3/4/25 did not include any further recording of assessments or vital signs for Resident J. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of vital sign records indicated Resident J's temperature was 97.5 on 2/13/25 at 10:00 PM and 97.4 on 2/15/25 at 11:55 AM. No additional temperature readings after 2/15/25 were available for review. In an interview, on 3/4/25 at 12:53 PM, Registered Nurse 7 indicated a resident receiving antibiotics for respiratory symptoms should have their breath sounds and temperature checked every shift. A current policy titled Physical Respiratory Evaluation Guidelines, dated 10/24/24, provided by the Director of Nursing on 3/4/25 at 1:55 PM indicated staff should observe the resident's respiratory rate, assess lung sounds, obtain oxygen saturation levels and observe for a cough. The policy did not address documentation guidelines. 2) Resident C's record was reviewed on 3/4/25 at 10:18AM. Diagnoses included non-traumatic brain dysfunction, abnormalities of gait, and weakness. Resident C's last annual, Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 5 (cognitively impaired). The MDS indicated Resident C required physical assistance to perform activities of daily living and the use of a walker. Resident C's progress notes were reviewed with unwitnessed falls documented on the following dates and times; 12/22/24 at 11:20 AM, 1/01/25 at 6:38 AM, 1/6/25 at 3:34 AM, 1/13/25 at 8:51 AM, and 2/8/25 at 2:14 AM. There was no documentation of refusal of neurological checks or reason for missed neurological checks. A neurological checklist started after the fall on 12/22/24. The checklost started at 11:40 AM, The last check was at 1200 noon. No other checks were recorded. There was a note on the form Resident C returned from the hospital on 12/26/24 without a time noted. The form indicated neuro checks should have continued until 12/30/24 but were not completed. A neurological checklist started after the fall on 1/13/25. The checklist started at 8:51 AM, was completed through 5:15 AM, then the following times were not documented. There was an entry at 11:15 PM. Then three non consecutive entries were completed. Three non consecutive entries were one blank. A neurological checklist started after the fall on 2/7/25. The checklist was completed through 2/9/25. A missed entry on 2/10/25 at 7:45AM followed by 2 completed entries. None of the entries dated 2/11/25, 2/12/25, and 2/15/25 were completed. 3) Resident D's record was reviewed on 3/4/25 at 10:30 AM. Diagnoses included Parkinson's disease. Resident D's last comprehensive, Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). The MDS indicated Resident D required physical assistance to perform activities of daily living and the use of a walker. Resident D's progress notes were reviewed with unwitnessed falls documented on the following dates and times; 10/24/24 at 1:06 AM, 10/24/24 at 9:20 AM, 10/24/24 at 2:01 PM, and 10/28/24 at 6:30 PM. There was no documentation for refusal of neurological checks or reason for missed neurological checks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A neurological checklist started after the fall on 10/24/24 at 12:30 AM. The checklist was completed until 1:15 PM then 3 entries were left blank, and it was resumed at 9:15 PM that evening. Three entries were made, then a missed entry on 10/27/24 at 1:15 PM. There were 2 completed entrees, then the form was marked off as it was indicated Resident D fell [DATE]. There was no restarting or stopping of the form for the subsequent falls on 10/24/24. A neurological checklist started after the fall on 10/28/24 at 6:30 PM. The form was mislabeled with dates, had 5 blank entries, illegible times and dates the checklist should have been completed. In an interview, on 3/4/25 at 11:14 AM, Licensed Practical Nurse (LPN) 2 indicated neurological checks should be completed on all residents who have an unwitnessed fall or strike their head during a fall. LPN 2 presented a neurological check form and reviewed the neurological check schedule. She reviewed in detail the expected intervals of neurological assessments. She indicated the neurological check form should be completely filled out with no blank spaces at the end of the monitoring period. She indicated any refusals or missed assessments should be explained in the progress notes. In an interview, on 3/4/25 at 1:06 PM, the Director of Nursing (DON) indicated the neurological checks form should be completed entirely, and any missed assessments should be explained in the Resident's progress notes. The DON acknowledged there was missing documentation in Resident C, and Resident D's neurological check forms presented. A current policy titled Guidelines for Incidents/Accidents/Falls was received by the DON on 3/4/25 at 11:11AM. The policy indicated .2. In the case of a fall, the resident will have a head to toe assessment to include a pain assessment as to any change in their range of motion ability or function. Further, residents who have an unwitnessed fall must have neuro checks started and continued per policy . This citation is related to complaints IN00450770 and IN00454234. 3.1-37