STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a known full code status (cardiopulmonary resuscitation [CPR] to be performed) received the appropriate emergency services as evidenced by a nurse (LPN 1) with an expired CPR certification starting CPR without a physical assessment, ceasing CPR without a medical evaluation, and failing to notify emergency services when the resident was found not breathing and without a heart rate for 1 of 3 residents reviewed for death. (Resident B). This deficient practice resulted in the facility's failure to provide CPR for Resident B during a medical event that resulted in death.The immediate jeopardy began on [DATE] when the facility failed to provide CPR as indicated by professional standards to a resident with a full code status who experienced a medical event resulting in death. The Administrator, Regional Operations Consultant, and Regional Nursing Consultant were present when informed of the immediate jeopardy on [DATE]. The immediate jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:Residents B's clinical record was reviewed on [DATE] at 11:59 a.m. Diagnoses included abdominal aortic aneurysm, chronic obstructive pulmonary disease, emphysema, hypertension, anorexia, vascular implants and chronic kidney disease.A physician order, dated [DATE], indicated an order for full code status.Review of the most current admission Minimal Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact.A care plan, dated [DATE], indicated the resident elected to be a full code.A progress note, dated [DATE] at 1:47 a.m. and written by LPN 1, indicated Resident B's oxygen saturation levels were 82%. A breathing treatment was started to see if it would help, but it did not. The resident's oxygen saturation dropped to 75% while on the breathing treatment. The resident's mouth was open, and they were very pale. The resident stopped breathing, and a heartbeat could not be heard. Chest compressions were started while the QMA was lowering the head of bed. Time of death was 1:55 a.m. on [DATE], after two rounds of chest compressions.The clinical record lacked documentation of notification to the physician/nurse practitioner of the resident's change in condition.The clinical record lacked documentation of emergency services being notified.An Event Note, dated [DATE] at 5:14 a.m. and written by LPN 1, indicated three rounds of compressions were completed, not two. The funeral home was called and arrived at 4:30 a.m. The nurse practitioner and Director of Nursing (DON) were notified. Per the resident's request, no family was called. During an interview on [DATE] at 6:08 p.m., LPN 1 indicated, on [DATE] during the night shift, she received a call from QMA 2, who was working on the secured unit, stating Resident B was not doing well. The secured unit had one CNA and one QMA working at the time. LPN 1 was the only nurse working, and was scheduled for the other units. LPN 1 indicated the resident had labored breathing and was pale. LPN 1 started a breathing treatment because that is what the Nurse Practitioner (NP) usually did, then she called the NP. QMA 2 stayed with the resident while LPN 1 went to prepare paperwork to send the resident out to the hospital. About halfway through the breathing treatment, the resident stopped breathing. LPN 1 indicated the resident was gone. She did three rounds of CPR, each consisting of 30 compressions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN 1 checked the resident again and found no breathing and no heart rate. LPN 1 indicated she thought the incident had lasted 20 minutes. She called the NP from the room using her personal phone and told her what she had done. The NP told her to stop the compressions/CPR. LPN 1 indicated she had a current CPR certification at the time of the incident. LPN 1 then indicated she would take the CPR class next week and was not sure if her certification had been current at the time of the incident. LPN 1 indicated she should have called for emergency services.During an interview on [DATE] at 9:30 a.m., the Nurse Practitioner (NP) indicated she had received three text messages from LPN 1 on [DATE]. The first message was at 1:23 a.m., and indicated Resident B was not doing well and the nurse was going to send the resident to the hospital. She was told QMA 2 was administering a breathing treatment. The resident's oxygen level was 86%. Staff were unable to get a blood pressure, even manually. The second message was at 1:38 a.m., indicating LPN 1 was sending the resident to the hospital. The third message was at 1:56 a.m., with LPN 1 indicating the chest compressions did not work and the resident had expired. The resident was not being sent to the hospital. During the interview, the NP indicated a breathing treatment is what she would have usually ordered in that situation. However, she was unaware the resident did not already have an order for breathing treatments. The NP did give an order for breathing treatments. The NP did not give an order to stop CPR.During an interview on [DATE] at 10:06 a.m. QMA 2 indicated she usually worked the night shift on the secured unit. She had gone to Resident B at around 10:30 p.m. and provided colostomy care. The QMA left the resident to get the supplies. When she returned, the resident was not really responding in his normal manner. CNA 4 was present and they were trying to get the resident to respond. LPN 1 was notified. The resident started to respond, and the QMA and CNA completed the care. Two hours later, the resident was not acting like his normal self and told the QMA repeatedly to sit him up. The resident denied difficulty breathing. QMA 2 called for LPN 1 again, gave her the resident's vital signs, and told her she thought the resident should be sent out. LPN 1 came to look at the resident and asked if the resident had a breathing treatment order. QMA 2 indicated she did not know if the resident had a breathing treatment order or not. LPN 1 indicated she was going to call the NP to see what she wanted them to do and told the QMA to go ahead and get a breathing treatment for the resident. QMA 2 indicated she got a nebulizer machine and an albuterol (bronchodilator) ampule. The resident did not have an order for albuterol, so QMA 2 took the medication from another resident. QMA 2 was unable to remember the name of the other resident. The QMA administered the medication. CNA 4 brought the vital signs machine and the QMA took vital signs while the breathing treatment was being administered. Approximately five minutes into the breathing treatment, QMA 2 noticed there was no rise or fall to the resident's chest. QMA 2 left the resident alone to find LPN 1and told her they needed to start CPR. The QMA adjusted the bed. LPN 1 started compressions. LPN 1 indicated she felt and heard a rib crack. LPN 1 asked QMA 2 if she thought that was resident's last breath. QMA 2 said probably. LPN 1indicated she was going to call it (end the code). LPN 1 stopped the compressions and said she was going to start making phone calls. QMA 2 indicated LPN 1 did not call the NP from the resident's room. QMA 2 indicated she had a current CPR certification. QMA 2 indicated she gave the albuterol breathing treatment because the nurse told her to.CNA 4 was unable to be reached for interview during the survey.During an interview on [DATE] at 1:29 p.m., the ADON indicated, in an emergency situation, she would call the health care provider on the phone. She would not text the provider. The resident would be assessed, and CPR would be initiated if appropriate until Emergency Medical Services (EMS) arrived to take over.During an interview on [DATE] at 1:36 p.m. LPN 5 indicated, in an emergency, she would first make sure the resident was alright. If the resident was not breathing, the code status would be confirmed. If they were a full code, someone would call 911 while CPR was initiated. They would never stop CPR until the EMS could take over. The medical provider should not be contacted via text message, but should be called on the telephone.Review of LPN 1's CPR certification on [DATE] at 8:36 a.m., from the American Heart Association Basic Life Support (CPR and AED) program was dated [DATE], with an expiration date of [DATE]. A new (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Certificate of Completion for Standard - CPR/AED, dated [DATE], lacked a hands-on component consistent with American Heart Association guidance.Review of QMA 2's CPR certification on [DATE] at 8:36 a.m., dated [DATE], lacked a hands-on component consistent with American Heart Association guidance.A current facility policy, dated [DATE] and titled Medical Emergencies That Require Immediate Response/Assessment was provided by the Corporate Clinical Consultant on [DATE] at 2:47 p.m. and indicated the following: . These symptoms must be reported immediately to the nurse in charge for evaluation and assessment. The nurse responds immediately and will determine if the resident requires further evaluation and treatment in an acute care setting. The nurse will notify the doctor and the resident's responsible party of the onset of these medical conditions for direction. If there is an emergent situation, the nurse will call 911 for EMS transport unless clearly defined by order and responsible party's direction not to do so --- such as in an actively dying resident.Review of American Heart Association's Resuscitation Education Science guidance, retrieved from https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/executive-summary indicated the following: .Part 12 of the 2025 Guidelines, Resuscitation Education Science, includes recommendations about various instructional design features in resuscitation training, including CPR feedback devices, rapid-cycle deliberate practice, scripted debriefing, gamified learning, spaced learning and booster training, teamwork and leadership training, manikin fidelity, virtual and augmented reality, and the use of cognitive aids. Recommendations for these instructional design elements have been split into those for health care professionals and those for lay rescuers. The immediate jeopardy that began on [DATE] was removed on [DATE] when the facility completed education with nursing staff regarding emergency response protocols and policies, but the noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because LPN 1 and QMA 2 remained without current CPR certification according to professional standards. This citation relates to Intake 2671519.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff provided care within their scope of practice as evidenced by LPN 1 giving medication orders for a nebulizer (breathing) treatment to QMA 2 without a physician order, QMA 2 administered the nebulizer treatment, staff failed to initiate emergency medical services, and LPN 1 made the determination to end CPR activities without indication. (Resident B) This deficient practice resulted in a delay in emergency medical treatment for a resident experiencing a change in condition that resulted in death. Findings include:Residents B's clinical record was reviewed on [DATE] at 11:59 a.m. Diagnoses included abdominal aortic aneurysm, chronic obstructive pulmonary disease, emphysema, hypertension, anorexia, vascular implants and chronic kidney disease.A physician order, dated [DATE], indicated an order for full code status.Review of the most current admission Minimal Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact.A care plan, dated [DATE], indicated the resident elected to be a full code.The clinical record lacked documentation of notification to the physician/nurse practitioner of the resident's change in condition.The clinical record lacked documentation of emergency services being notified.A progress note, dated [DATE] at 1:47 a.m. and written by LPN 1, indicated Resident B's oxygen saturation levels were 82%. A breathing treatment was started to see if it would help, but it did not. The resident's oxygen saturation dropped to 75% while on the breathing treatment. The resident's mouth was open, and they were very pale. The resident stopped breathing, and a heartbeat could not be heard. Chest compressions were started while the QMA was lowering the head of bed. Time of death was 1:55 a.m. on [DATE], after two rounds of chest compressions.An Event Note, dated [DATE] at 5:14 a.m. and written by LPN 1, indicated three rounds of compressions were completed, not two. The funeral home was called and arrived at 4:30 a.m. The nurse practitioner and Director of Nursing (DON) were notified. Per the resident's request, no family was called. During an interview on [DATE] at 6:08 p.m., LPN 1 indicated, on [DATE] during the night shift, she received a call from QMA 2, who was working on the secured unit, stating Resident B was not doing well. The secured unit had one CNA and one QMA working at the time. LPN 1 was the only nurse working, and was scheduled for the other units. LPN 1 indicated the resident had labored breathing and was pale. LPN 1 started a breathing treatment because that is what the Nurse Practitioner (NP) usually did, then she called the NP. QMA 2 stayed with the resident while LPN 1 went to prepare paperwork to send the resident out to the hospital. About halfway through the breathing treatment, the resident stopped breathing. LPN 1 indicated the resident was gone. She did three rounds of CPR, each consisting of 30 compressions. LPN 1 checked the resident again and found no breathing and no heart rate. LPN 1 indicated she thought the incident had lasted 20 minutes. She called the NP from the room using her personal phone and told her what she had done. The NP told her to stop the compressions/CPR. LPN 1 indicated she had a current CPR certification at the time of the incident. LPN 1 then indicated she would take the CPR class next week and was not sure if her certification had been current at the time of the incident. LPN 1 indicated she should have called for emergency services.During an interview on [DATE] at 9:30 a.m., the Nurse Practitioner (NP) indicated she had received three text messages from LPN 1 on [DATE]. The first message was at 1:23 a.m., and indicated Resident B was not doing well and the nurse was going to send the resident to the hospital. She was told QMA 2 was administering a breathing treatment. The resident's oxygen level was 86%. Staff were unable to get a blood pressure, even manually. The second message was at 1:38 a.m., indicating LPN 1 was sending the resident to the hospital. The third message was at 1:56 a.m., with LPN 1 indicating the chest compressions did not work and the resident had expired. The resident was not being sent to the hospital. During the interview, the NP indicated a breathing treatment is what she would have usually ordered in that situation. However, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0726 Level of Harm - Actual harm Residents Affected - Few	she was unaware the resident did not already have an order for breathing treatments. The NP did give an order for breathing treatments. The NP did not give an order to stop CPR.During an interview on [DATE] at 10:06 a.m. QMA 2 indicated she usually worked the night shift on the secured unit. She had gone to Resident B at around 10:30 p.m. and provided colostomy care. The QMA left the resident to get the supplies. When she returned, the resident was not really responding in his normal manner. CNA 4 was present and they were trying to get the resident to respond. LPN 1 was notified. The resident started to respond, and the QMA and CNA completed the care. Two hours later, the resident was not acting like his normal self and told the QMA repeatedly to sit him up. The resident denied difficulty breathing. QMA 2 called for LPN 1 again, gave her the resident's vital signs, and told her she thought the resident should be sent out. LPN 1 came to look at the resident and asked if the resident had a breathing treatment order. QMA 2 indicated she did not know if the resident had a breathing treatment order or not. LPN 1 indicated she was going to call the NP to see what she wanted them to do and told the QMA to go ahead and get a breathing treatment for the resident. QMA 2 indicated she got a nebulizer machine and an albuterol (bronchodilator) ampule. The resident did not have an order for albuterol, so QMA 2 took the medication from another resident. QMA 2 was unable to remember the name of the other resident. The QMA administered the medication. CNA 4 brought the vital signs machine and the QMA took vital signs while the breathing treatment was being administered. Approximately five minutes into the breathing treatment, QMA 2 noticed there was no rise or fall to the resident's chest. QMA 2 left the resident alone to find LPN 1and told her they needed to start CPR. The QMA adjusted the bed. LPN 1 started compressions. LPN 1 indicated she felt and heard a rib crack. LPN 1 asked QMA 2 if she thought that was resident's last breath. QMA 2 said probably. LPN 1indicated she was going to call it (end the code). LPN 1 stopped the compressions and said she was going to start making phone calls. QMA 2 indicated LPN 1 did not call the NP from the resident's room. QMA 2 indicated she had a current CPR certification. QMA 2 indicated she gave the albuterol breathing treatment because the nurse told her to.CNA 4 was unable to be reached for interview during the survey.During an interview on[DATE] at 1:29 p.m., the ADON indicated, in an emergency situation, she would call the health care provider on the phone. She would not text the provider. The resident would be assessed, and CPR would be initiated if appropriate until Emergency Medical Services (EMS) arrived to take over.During an interview on [DATE] at 1:36 p.m. LPN 5 indicated, in an emergency, she would first make sure the resident was alright. If the resident was not breathing, the code status would be confirmed. If they were a full code, someone would call 911 while CPR was initiated. They would never stop CPR until the EMS could take over. The medical provider should not be contacted via text message, but should be called on the telephone.Review of LPN 1's CPR certification on [DATE] at 8:36 a.m., from the American Heart Association Basic Life Support (CPR and AED) program was dated [DATE], with an expiration date of [DATE]. A new Certificate of Completion for Standard - CPR/AED, dated [DATE], lacked a hands-on component consistent with American Heart Association guidance.Review of QMA 2's CPR certification on [DATE] at 8:36 a.m., dated [DATE], lacked a hands-on component consistent with American Heart Association guidance.Review of the Indiana Nurse Practice Act, retrieved from https://www.in.gov.doe.files, indicated the following: . 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate interpersonal behaviors in providing nursing care. (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience. (11) Diverting prescription drugs for own or another person's use.Review of the current Indiana QMA Scope of Practice, retrieved from https://www.in.gov/health/ltc/aide-training-and-certification/qma/ indicated the following: .The following tasks shall NOT be included in the QMA scope of practice:. (2) Administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	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 0726 Level of Harm - Actual harm Residents Affected - Few	inhalation treatments, such as nebulizers. A current facility policy, dated [DATE] and titled Medical Emergencies That Require Immediate Response/Assessment, provided by the Corporate Clinical Consultant on [DATE] at 2:47 p.m., indicated the following: . These symptoms must be reported immediately to the nurse in charge for evaluation and assessment. The nurse respond immediately and will determine if the resident requires further evaluation and treatment in an acute care setting. The nurse will notify the doctor and the resident's responsible party of the onset of these medical conditions for direction. If there is an emergent situation, the nurse will call 911 for EMS transport unless clearly defined by order and responsible party's direction not to do so --- such as in an actively dying resident.This citation relates to Intake 2671519.3.1-14(i)