

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Waters of Hobart Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37th Ave Hobart, IN 46342	
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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure antihypertensive medications and insulin were held per parameters for 1 of 2 residents reviewed for blood pressure parameters and 1 of 2 residents reviewed for insulin. The facility also failed to ensure follow-up documentation was completed after a fall for 1 of 3 residents reviewed for a change in condition and dry scaly feet were assessed and treated for 1 of 2 residents reviewed for non-pressure related skin conditions. (Residents M, L, E, and N) Findings include: 1. The record for Resident M was reviewed on 7/21/26 at 10:11 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 6/10/26, indicated the resident was cognitively impaired for daily decision making. A Care Plan, reviewed on 6/23/26, indicated the resident had a diagnosis of hypertension and was receiving antihypertensive medications. Interventions included, but were not limited to, administer prescribed medications as ordered. A Physician's Order, dated 7/10/25 and listed as current on the July 2026 Physician's Order Summary (POS), indicated the resident was to receive Carvedilol (a medication used to treat high blood pressure) 6.25 milligrams (mg) twice a day for hypertension. Hold the medication for a systolic (top number) blood pressure of less than 110 and pulse less than 60. The May 2026 Medication Administration Record (MAR) indicated the resident's AM (morning) pulse on 5/27/26 was 58 and the medication was given. The June 2026 MAR indicated the resident's AM and HS (evening) pulse was below 60 on the following dates and the medication was given: - 6/8/26 AM pulse 58 - 6/25/26 AM pulse 58 (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 - Some	- 6/16/26 HS pulse 58 - 6/18/26 HS pulse 58 On 6/9/26 the resident's AM blood pressure was 99/55 and the medication was given. On 6/26/26, the resident's AM blood pressure was 107/66 and the medication was given. The July 2026 MAR indicated on 7/4/26 and 7/7/26 the resident's pulse was 58. The resident received the medication when it should have been held. During an interview on 7/22/26 at 3:45 p.m., the Nurse Consultant indicated the resident's medication should have been held per the parameters. 2. The record for Resident E was reviewed on 7/21/26 at 2:22 p.m. Diagnoses included, but were not limited to, hip surgery, adult failure to thrive, abnormalities of gait, unsteadiness on feet, weakness, anxiety disorder, and Alzheimer's dementia late onset. The 6/18/26 Modification of the Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making and had no range of motion physical impairments. The resident needed partial to moderate assistance with transfers and supervision or touch assistance with ambulating. The resident had one fall with no injury since the last assessment. A Care Plan, revised 7/16/26, indicated the resident was at risk for falls. An e-Interact Change in Condition Evaluation, dated 7/15/26, indicated the resident had a fall in the afternoon on 7/15/26 with no injury. The 72 hour follow up incident charting occurred on 7/15/26 at 6:48 p.m., 7/16/26 at 3:45 a.m., 7/16/26 at 10:40 a.m., 7/16/26 at 10:58 p.m., 7/17/26 at 11:39 a.m., and 7/17/26 at 7:31 p.m. There was no follow up after the fall after 7/17/24 at 7:31 p.m. A Nurse's Note, dated 7/17/26 at 10:13 a.m., indicated the IDT (interdisciplinary team) met to discuss the resident's recent fall which occurred by the vending machines she was using by herself per her norm. The IDT decided to provide oversight and assistance as needed when she was at the vending machines especially when she was retrieving items after purchase. During an interview on 7/22/26 at 2:00 p.m., the Assistant Director of Nursing (ADON) indicated follow up after a fall was supposed to be documented for 72 hours. During an interview on 7/22/26 at 3:10 p.m., the Regional Nurse Consultant indicated documentation after a fall should be for 72 hours. The 6/20/23 and identified as current Guidelines for Incidents/Accidents/Falls policy, provided by the Administrator on 7/23/26 at 12:16 p.m., indicated documentation after an incident/accident of the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physical and mental status of the resident(s) involved will be completed each shift (every eight hours minimally) over at least the next 72 hours or until the resident(s)'s condition improved. 3. The record for Resident L was reviewed on 7/20/26 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes. The 6/30/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received insulin injections. A Care Plan, revised 7/2026, indicated the resident was at risk for unstable blood glucose related to the diagnosis of diabetes. The approaches were to administer insulin as ordered. A Physician's Order, dated 8/5/25, indicated Insulin Aspart (a rapid-acting insulin) 100 units per milliliter, inject 20 units subcutaneously with meals, hold if glucose was less than 110. The 4/2026 Medication Administration Record (MAR) indicated the Insulin Aspart was administered on the following days when the resident's blood sugar was less than 110: 8:00 a.m. on 4/25/26, the blood sugar was 101. 5:00 p.m. on 4/3/26, the blood sugar was 94. The 5/2026 Medication Administration Record (MAR) indicated the Insulin Aspart was administered on the following days when the resident's blood sugar was less than 110: 8:00 a.m. on 5/21/26, the blood sugar was 94. 5:00 p.m. on 5/8/26 the blood sugar was 109, on 5/20/26 the blood sugar was 95, and on 5/27 and 5/28/26 the blood sugars were 80. The 6/2026 Medication Administration Record (MAR) indicated the Insulin Aspart was administered on the following days when the resident's blood sugar was less than 110: 8:00 a.m. on 6/26/26 the blood sugar was 102, on 6/27/26 the blood sugar was 92, and on 6/28/26 the blood sugar was 109. 5:00 p.m. on 6/1/26 the blood sugar was 103, on 6/24/26 the blood sugar was 67, on 6/27/26 the blood sugar was 83, and on 6/28/26 the blood sugar was 87. The 7/2026 Medication Administration Record (MAR) indicated the Insulin Aspart was administered on the following days when the resident's blood sugar was less than 110: 8:00 a.m. on 7/4/26 the blood sugar was 109, on 7/5/26 the blood sugar was 100. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5:00 p.m. on 7/6/26 the blood sugar was 62, on 7/8/26 the blood sugar was 78, and on 7/11/26 the blood sugar was 100. During an interview on 7/22/26 at 3:10 p.m., the Regional Nurse Consultant had no additional information to provide. 4. On 7/19/26 at 2:16 p.m., Resident N was resting in bed. The skin on his lower legs was dry and scaly with small scabs. A stain of dried blood was on the cuff of his left sock. The resident indicated his legs were itchy and dry. He tried to put lotion on, but he could not reach. On 7/22/26 at 11:00 a.m., LPN 4 removed the resident's socks. Large amounts white skin flakes on came off when the socks were removed. There was a row of small scabs on the resident's left shin and a dime-sized scab on his right shin. At that time, LPN 4 indicated the resident needed lotion on his legs. There was no lotion in his room. The resident indicated he would like to have lotion put on his legs. The record for Resident 3 was reviewed on 7/22/26 at 10:55 a.m. Diagnoses included, but were not limited to, heart disease, diabetes, and morbid obesity. The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/26, indicated the resident had moderate cognitive impairment, and required moderate assistance with activities of daily living (ADLs). The last Weekly Skin Check was documented on 7/4/26. The record lacked documentation of the dry, scaly, scabbed skin as well as treatment or refusal of treatment . A Care Plan, reviewed on 7/22/26, indicated the resident was at increased risk for impaired skin integrity, and had a history of venous ulcers (wounds caused by poor circulation) to his lower leg. Interventions included checking skin during routine care on a daily basis. During an interview on 7/22/26 at 3:30 p.m., the Nurse Consultant was informed of findings and provided no additional information. A policy titled, Guidelines for Preventive Skin Care, received as current from the Administrator on 7/23/26 at 12:16 p.m., indicated appropriate skin care should be provided by staff each shift and / or as necessary. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a) This citation relates to Intake 2990870.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to the improper storage of bed pans and urinals during random room observations and staff failing to wear the correct personal protective equipment (PPE) for residents in droplet and enhanced barrier precautions for 2 of 2 units. (The East and [NAME] Units, Residents O and K) Findings include: 1. During a random observation on 7/19/26 at 8:50 a.m., a half full urinal was observed on the over bed table in room [ROOM NUMBER] on the East Unit. 2. During a random observation on 7/19/26 at 9:09 a.m., a half full urinal was observed hanging from the side rail of the bed in room [ROOM NUMBER] on the East Unit. 3. On 7/19/26 at 11:03 a.m., LPN 2 was observed to donn an isolation gown, gloves, and a mask and enter Resident O's room. There was a sign on the resident's door indicating he was in droplet precautions. The verbiage on the sign indicated a gown, gloves, mask, and eye protection was to be worn while in the room. On 7/20/26 at 9:28 a.m., CNA 3 was observed to enter Resident O's room. She took an isolation gown into the resident's room and did not donn it in the hallway prior to entering. At 9:36 a.m., the CNA opened the door to the resident's room and she was wearing an isolation gown and gloves. She was not wearing a mask or a face shield. She used her gloved hand to retrieve something off of the linen cart. At 9:49 a.m., the CNA again entered the resident's room. She donned a gown in the hallway and carried gloves and a garbage bag into the room. She was not wearing a mask or eye protection when she went back into the resident's room. At 9:50 a.m., she opened the door and reached out with her gloved hand and retrieved a draw sheet from the top of the linen cart. She was not wearing a mask or eye protection when she opened the door. At 10:11 a.m., Activity Aide 1 was observed entering the resident's room. She did not donn any personal protective equipment (PPE) prior to entering the room. At 10:40 a.m., LPN 2 donned a gown, mask, and gloves prior to entering the resident's room, however, she was not wearing any face protection. During an interview on 7/20/26 at 1:15 p.m., LPN 2 indicated the resident was in isolation due to rhinovirus (a highly contagious RNA virus that spreads via airborne droplets or contaminated surfaces). During an interview on 7/22/26 at 3:30 p.m., the Nurse Consultant indicated PPE including a face shield should have been donned by staff prior to entering the resident's room. The Acute Respiratory Illness policy provided by the Nurse Consultant and identified as current indicated HCP (Health Care Professionals) who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV2 infection should adhere to Standard Precautions and use a NIOSH approved N95 facemask, gown, gloves, and eye protection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Center for Disease Control (CDC) recommended the four following essential items of PPE for droplet precautions: - Surgical Mask: Worn to prevent the inhalation of large-particle droplets from coughing, sneezing, or talking. - Eye Protection: Includes goggles or a face shield to protect the eyes from splashes or spray. - Gown: Worn to protect clothing and skin from contamination during close patient contact. - Gloves: Worn to prevent hand contamination 4. During a random observation on 7/20/26 at 10:19 a.m., Resident K was observed in bed with an indwelling Foley (urinary) catheter and a peg tube (a tube inserted directly into the stomach for nutrition). At that time, CNA 2 was standing at the resident's bedside wearing gloves to both hands and no isolation gown. The CNA was providing incontinence care for the resident. At 10:28 a.m., the CNA removed her gloves, performed hand hygiene and donned a clean pair of gloves to both hands. She then assisted the resident to a sitting position to the side of the bed, placed the gait belt around the resident's waist, and lifted her into the wheelchair. She did not wear an isolation gown prior to the transfer. The record for Resident K was reviewed on 7/21/20 at 3:58 p.m. Diagnoses included, but were not limited to, dementia, adult failure to thrive, and obstructive and reflux uropathy (trapped urine backup and abnormal backward flow in the urinary system). The 6/30/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling catheter. A Care Plan, revised on 6/25/26, indicated the resident was in Enhanced Barrier Precautions (EBP) for a feeding tube and a catheter. The approaches were to follow EBP guidelines when providing care and coming in direct contact with the resident, for example changing briefs, incontinence care and transfers. A Physician's Order, dated 7/20/26, indicated enhanced barrier precautions for catheter and peg tube. During an interview on 7/23/26 at 11:00 a.m., the Infection Prevention Nurse and the Assistant Director of Nursing (ADON) indicated they were both aware of CNA 2's actions and not wearing an isolation gown while providing care for the resident. The ADON indicated she should have worn an isolation gown when coming in contact with the resident. The current and revised 2/2023 Guidelines for Infection Control policy provided by the Administrator on 7/22/26 at 4:15 p.m., indicated EBP required use of gloves and a gown if coming in contact with the resident. This citation relates to Intake 2990870. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)		