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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Sullivan Nursing Facility, The	505 W Wolfe St Sullivan, IN 47882

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide meals that were palatable during 2 of 2 mealtime observations. This deficient practice had the potential to affect 52 of 52 residents receiving food served from the kitchen. Findings include:During breakfast meal service in the main dining room on 7/28/25 at 8:03 a.m., a breakfast menu was noted to be dated 7/11/25 and indicated breakfast trays were served at 7:45 a.m. The first breakfast tray was served at 8:23 a.m. On 7/28/25 at 8:23 a.m., Certified Nurse's Aide (CNA) 11 served a male resident his breakfast tray and indicated she was unable to cut the waffle very easily because it was hard and crunchy. The waffle was noted to be dark brown and hard on half of it. During an interview, on 7/28/25 at 8:35 a.m., Resident 61 indicated he was unable to eat his waffle because it was overcooked and too hard to cut with a butter knife. During an interview, on 7/28/25 at 8:40 a.m., Resident 40 indicated he didn't have waffles or biscuits on his plate this morning, but they appeared to be overcooked and too hard to cut because his table mate was unable to eat hers. During an interview, on 7/28/25 at 1:45 p.m., Resident 60 indicated she was unable to eat most of her lunch meal because the French fries were overcooked and too crunchy to eat, she didn't like the pizza crust because there was too much of it and it was hard to chew. There was no protein on the pizza, just cheese. Resident 60 was not sure why the facility would pair pizza and French fries together in the first place. During an interview, on 7/29/25 at 8:56 a.m., Resident 36 indicated the food at the facility was not good. She indicated the waffles and biscuits were hard if they served them and her eggs were never cooked right. The yellow yolk of the eggs appeared to be gel like on her breakfast tray. Review of May, June, and July resident council meeting minutes indicated residents had concerns with food palatability each month. During an interview, on 7/31/25 at 1:15 p.m., the Regional Director of Operations (RDO) indicated the facility was aware of the ongoing kitchen concerns and how the food was being prepared. She indicated the food was not being prepared properly and they now have all new staff in the kitchen. She thought the food was being cooked all together and was being left out for too long and that was why the food was hard and crunchy. The day the kitchen served pizza it should have contained a protein and should not have been served with French fries, there should have been a salad or [NAME] slaw served with it not another starch. She was aware that the food being prepared by the kitchen was unacceptable. During an interview, on 7/31/23 at 2:45 p.m., the Administrator indicated the facility was aware of the kitchen concerns and they were working on getting new cooks and a Dietary Manager for the kitchen. On 7/31/25 at 3:00 p.m., the Administrator provided an undated document, titled, The Dining Service, and indicated it was the policy currently being used by the facility. The policy indicated, .6. Meals will be nourishing, attractive, palatable, .On 7/31/25 at 3:00 p.m., the Administrator provided a document with a revised date of 1/2025, titled, Menu & Nutritional Adequacy, and indicated it was the policy currently being used by the facility. The policy indicated, .Meals will be prepared and served in an attractive manner that enhances palatability.3.1-21(a)(1)3.1-21(a)(2)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to ensure a male cook with a full beard was wearing a beard restraint during food preparation and that the high temperature dish machine reached the proper temperature for the rinse cycle for 1 of 2 kitchen observations. This deficient practice had the potential to affect 52 of 52 residents receiving food served from the kitchen. B. Based on observation, interview, and record review, the facility failed to ensure proper handling of food during 1 of 1 lunchtime hall tray observations. Findings include: A. During the initial tour of the kitchen with the Dietary Manager, on 7/28/25 at 7:36 a.m., the following was observed: 1. On 7/28/25 at 7:40 a.m., [NAME] 6 was observed with a full beard. He was not wearing any beard restraint cover while preparing food for the breakfast meal. The visitor provided a beard restraint for the cook. At the same time, the Dietary Manager indicated the facility was aware that there were no beard restraints and they had placed an order for the restraints. During an interview, on 7/29/25 at 9:48 a.m., the Administrator (ADM) indicated she was not aware that the cook had been working without a beard restraint. During an interview, on 7/31/25 at 11:48 a.m., the Regional Director of Operations (RDO) indicated she was aware that there were no beard restraints available. The cook was the first male staff that had worked in the kitchen with a beard. They had beard restraints on order. On 7/28/25 at 1:51 p.m., the ADM provided a document, dated 4/2017, titled, Food Safety and Sanitation Employee Health and Personal Hygiene, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.Hair restraints will be worn at all times. Beards should be well-trimmed and covered with an appropriate hair restraint. 2. On 7/28/25 at 7:49 a.m., observation of the high temperature dish machine indicated the rinse cycle temperature only reached a temperature of 174 degrees Fahrenheit (F). At the same time, the Dietary Manager indicated the temperature should reach at least 180 degrees F for the rinse cycle to sanitize the dishes. There had been a problem with the dish machine's booster (a device that boosts the temperature of the water during the rinse cycle) and she had reported this to the Maintenance Director. During an interview, on 7/28/25 at 8:49 a.m., the Administrator (ADM) indicated she had not been made aware of the dish machine not getting up to the proper rinse temperature. She would make sure the Maintenance Director was aware and that the kitchen staff would use paper and plastic items until the machine was functioning properly again. During an interview, on 7/29/25 at 9:48 a.m., the ADM indicated there had been some concerns with the Dietary Manager's job performance. She had been a no-call/no-show for her shift on this date. She would no longer hold that position and they would be looking for a new manager in the kitchen. On 7/28/25 at 1:51 p.m., the ADM provided a document, dated 4/2017, titled, Food Safety and Sanitation Machine Dishwashing and indicated it was the policy currently being used by the facility. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy indicated, .Procedure.High temperature dish machine has a final sanitizing rinse of at least 180 degrees F. B. On 7/28/25 at 12:45 p.m., A drink cart was noted on the East wing hallway, the cart contained a metal bucket of ice and the bucket did not contain a lid, the ice was open to air and there was a metal scoop in the ice bucket. The drink cart was moved down the hallway by room [ROOM NUMBER] and was pushed by Licensed Practical Nurse (LPN) 16. A drink was prepared by the LPN and the ice scoop was placed in the opened metal ice bucket. The drink cart was left by room [ROOM NUMBER] until 12:48 p.m. The Director of Nursing (DON) pushed the cart up to the nurses' station and left the cart at the nurses' station. The cart contained an ice bucket that was left open to air and contained an ice scoop still in the bucket. On 7/28/15 at 1:10 p.m., the drink cart continued to be sitting at the nurses' station. The metal scoop was noted to still be in the ice bucket with the ice melting. There was no staff currently by the nurse's station. On 7/28/25 at 12:53 p.m., A drink cart was noted be at the nurses' station on the [NAME] wing, the cart contained a metal bucket that did not contain a lid, and the ice was open to air. There was no scoop in the ice bucket. There were 3 plastic drinking cups of ice on the second shelf of the cart and they were left open to air with no lids on them. On 7/28/25 at 1:13 p.m. Activity Aide 15 pushed the cart down the hallway and took a plastic drinking cup and scooped ice out of the ice bucket into the cup. The activity aide poured lemonade into the cup that contained the ice, she served it to the resident with their lunch tray. On 7/28/25 at 1:13 p.m., a housekeeper was observed to be pushing her cart down the hallway as staff were serving lunch hall trays. During an interview, on 7/28/25 at 1:20 p.m., the DON indicated the lid was removed from the ice bucket when the drink cart left the kitchen. She was not aware it should be covered while out in the hallway. During an interview, on 7/28/25 at 1:35 p.m., the Regional Nurse Consultant (RNC) indicated ice should be covered when the leaving the kitchen and staff should not leave the scoop in the ice bucket or use drinking glasses to scoop ice into and then use. During an interview, on 7/28/25 at 1:38 p.m., the DON indicated the facility had decided to no longer use the ice buckets during meal service and use the ice coolers on the hallways instead. She indicated the coolers had lids and ice scoops with a designated container for them to remain in while not in use. She had provided education to staff as well. On 7/28/25 at 1:40 p.m., the Administrator provided an undated document, titled, Serving Food and Beverages, and indicated it was the policy currently being used by the facility. The policy indicated, .6. Foods will be covered when not being served . 10. All food/beverages will be covered if transported to residents that are eating in their room, or to a dining room that is not adjacent to kitchen 3.1-21(i)(3)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure a resident's call light was kept within reach for 1 of 24 residents reviewed for call lights (Resident 7). Findings include:On 7/28/25 at 9:35 a.m., Resident 7 was observed lying in bed. The resident's call light was lying on the recliner next to her bed and was out of the resident's reach. At the same time, the resident indicated the call light was not within her reach. On 8/1/25 at 9:03 a.m., Resident 7 was observed lying in bed with the call light under the pillow and out of her reach. At the same time, the resident indicated she did not know where her call light was and was unable to find it. The resident indicated she would yell for help if she needed something but would have used the call light if she had it. Resident 7's record was reviewed on 7/31/25 at 9:14 a.m. Diagnoses on the resident's profile included, but were not limited to, moderate vascular dementia (a disruption in blood flow to the brain leading to damage in brain tissue) with anxiety and history of falling. A quarterly Minimum Data Set (MDS) assessment, dated 7/6/25, indicated the resident had severe cognitive impairment and required moderate staff assistance with transfers. Current care plans indicated the resident required staff assistance with activities of daily living (ADLs) and was at risk of falls. During an interview, on 8/2/25 at 9:17 a.m., Licensed Practical Nurse (LPN) 16 indicated Resident 7 was capable of using her call light, and it should have been within her reach. During an interview, on 8/1/25 at 9:19 a.m., the Director of Nursing (DON) indicated the resident was able to use her call light, and it should have been kept within her reach. On 8/1/25 at 9:36 a.m., the DON provided a document titled, Call Light, Use of, dated 2006, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure Details.8. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light.11. Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. 3.1-3(v)(1)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview and record review, the facility failed to ensure prompt response regarding resident council grievances for 3 of 3 resident council meetings reviewed. Findings include:On 7/28/25 during initial observation, the daily menu posted was dated 7/11/25. Subsequent daily survey observations noted the daily menu had not been posted.On 7/31/25 at 1:00 p.m., during resident council meeting, the Resident Council President presented several concerns the residents had presented to him during the council meetings. He asked for the daily meal menu to be posted and indicated it had not been done. The residents were to choose a meal of their choice once a month; they chose a meal, but it was not served to them.He indicated if the facility had snacks available, they would pass them out. He was told the budget did not allow the facility to purchase snacks. The resident indicated he was a diabetic and he purchased snacks to keep in his room. He had snacks if needed but other diabetic residents had reported to him they had not received snacks.He indicated grievances were not responded to him or other residents.On 7/31/25 at 1:45 p.m., during interview the Administrator indicated the resident's grievances were addressed in daily stand up and stand down meetings, and the response to the grievance should be written on the grievance form. She indicated the kitchen should provide snacks daily for the residents and if they did not have food supplies, she would ensure they were available.Review of the resident council minutes from 5/27/25 to 7/29/25 indicated grievances were presented. The documentation lacked evidence of follow-up responses to complaints.On 8/1/2025 at 9:43 p.m., the Administrator provided a document titled, Resident council Policy, dated 3/1/16, and indicated it was the policy currently being used by the facility. The policy indicated, .Group Concerns and Follow-Up.The council group members who voice a concern usually expect a timely response about the resolution to their concern. This must happen. The Administrator monitors this process. Concerns-When concerns are voiced show serious interest and approach follow-up on all concerns and GET BACK WITH RESOLUTION/Document demonstrate that all concerns/requests brought up by the council either individually or by the group are very important.3.1-3(l)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to ensure a resident's representative was notified of a new order for 1 of 4 resident representative interviews (Resident 7). Findings include:On 7/28/25 at 9:35 a.m., Resident 7's room was observed with a contact precautions (a set of infection control practices used in healthcare settings to prevent the spread of germs that can be transmitted by direct or indirect contact with a patient or their environment) isolation sign on the wall next to the door. During an interview, on 7/28/25 at 1:12 p.m., Resident 7's representative indicated they were not aware the resident was on isolation precautions or why they were in place. They were not notified the resident was placed on isolation precautions. Resident 7's record was reviewed on 7/31/25 at 9:14 a.m. Diagnoses on the resident's profile included, but were not limited to, moderate vascular dementia (a disruption in blood flow to the brain leading to damage in brain tissue) with anxiety and urinary tract infection (UTI). A quarterly Minimum Data Set (MDS) assessment, dated 7/6/25, indicated the resident had severe cognitive impairment. A nursing progress note, dated 7/21/25, at 12:36 p.m., indicated the physician ordered Macrobid (antibiotic) for seven days for a UTI. A nursing progress note, dated 7/21/25 at 12:49 p.m., indicated the resident's representative was notified of the antibiotic order but lacked documentation the resident's representative was notified of isolation precautions. A physician's order, dated 7/23/25, indicated contact isolation precautions for Escherichia coli (E. coli) (bacteria) in the urine until 7/29/25. The order lacked documentation the resident's representative was notified of the new order. A current care plan indicated the resident was on isolation precautions related to E. coli in the urine. On 7/31/25 at 11:49 a.m., the Director of Nursing (DON) provided a Nurse Practitioner (NP) progress note and indicated it was documentation the NP notified the resident's representative of the contact isolation precautions order. The NP progress note, dated 7/23/25, indicated, .This pt [patient]/family was made aware that this visit is being performed using remote telephonic technology. The note lacked documentation the resident's representative was notified of the contact isolation precautions order. The DON indicated she was not able to provide any additional documentation to support the resident's representative was notified of the order. On 7/31/25 at 11:57 a.m., the DON provided a document titled, Change in a Resident's Condition or Status, last revised in 2021, and indicated it was the policy currently being used by the facility. The policy indicated, .Our facility promptly notifies.the resident representative of changes in the resident's medical.condition and/or status.Policy Interpretation and Implementation.4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when.b. there is a significant change in the resident's physical.status.5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical.condition or status. 3.1-5(a)(3)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to ensure an Advance Beneficiary Notice (ABN) (written notice to inform a Medicare beneficiary when they can expect Medicare to deny payment for services) form as required for 2 of 3 residents reviewed for beneficiary notices (Residents 62 and 19). Findings include:Findings include: 1. Resident 62's record was reviewed on 8/1/25 at 10:55 a.m. A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review, completed by the Business Office Manager (BOM), indicated the resident's Medicare Part A stay started on 3/1/25, and the last Medicare Part A stay covered day was 4/30/25. The facility initiated the discharge from Medicare Part A Services when benefit days were not yet exhausted. A Notice of Medicare Non-Coverage (NOMNC) (a document that Medicare providers must give to beneficiaries when their Medicare-covered services are ending), was signed by the resident on 4/28/25.The record lacked documentation an ABN was provided with the NOMNC. 2. Resident 19's record was reviewed on 8/1/25 at 10:48 a.m. A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review, completed by the Business Office Manager (BOM), indicated the resident's Medicare Part A stay started on 1/27/25, and the last Medicare Part A stay covered day was 3/24/25. The facility initiated the discharge from Medicare Part A Services when benefit days were not yet exhausted. A Notice of Medicare Non-Coverage (NOMNC) (a document that Medicare providers must give to beneficiaries when their Medicare-covered services are ending), was signed by the resident's representative on 3/18/25. The record lacked documentation an ABN was provided with the NOMNC. During an interview, on 8/1/25 at 10:57 a.m., the BOM indicated ABNs were not provided to Residents 62 and 19 because they were provided a detailed NOMNC. She was not aware she still needed to issue them an ABN. On 8/1/25 at 11:11 a.m., the Administrator provided an undated document titled, Form Instructions Advance Beneficiary Notice of Noncoverage (ABN), and indicated it was the policy currently being used by the facility. The policy indicated, .Overview: The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case.All of the aforementioned.providers must complete the ABN as described below, and deliver the notice to the affected beneficiaries or their representative before providing the items or services that are the subject of the notice. 3.1-4(f)(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to ensure staff immediately reported an abuse allegation to the Administrator for 1 of 1 reportable incidents reviewed (Resident 23). Findings include:On 7/29/25 at 11:30 a.m., a police officer answered a knock at the Administrator's office door and indicated the Administrator was not available because she went to find a resident. At the same time, the Director of Nursing (DON) indicated the police officer was at the facility because a reportable incident had occurred. During an interview, on 7/29/25 at 2:01 p.m., the Administrator indicated Resident 23 reported another resident touched her shoulder inappropriately while making a sexual advance towards her. The Administrator indicated the staff had not reported the incident to her immediately and instead left a note under the Social Services Director's (SSD) door. The resident reported the incident to the evening/night shift Qualified Medication Aide (QMA) who reported it to the evening/night shift nurse. The nurse left a note for the SSD but did not call the Administrator. Resident 23's record was reviewed on 7/30/25 at 11:30 a.m. An admission Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the resident was cognitively intact and did not have behaviors during the assessment look-back period. A current care plan indicated the resident had experienced significant trauma throughout her life and was a trauma survivor. An incident investigation file included the following documents: An undated handwritten note indicated, I wasn't sure what to do about this. I'm working nights and wasn't sure if you would be here before I left. [Resident 23] told [QMA 13] about it. I guess [Resident 23] was very upset about it everything [male resident's name] is saying and him touching her. She is afraid to say anything to him to stop because she isn't sure how he will react. A behavior tracking tool, dated 7/28/25, indicated Resident 23 reported to a QMA that an identified male resident has been saying, she is the perfect height for her to do what he needs. The male resident has been massaging Resident 23's back. Resident 23 did not want him to do that, and she was scared to tell him to stop. A statement from Resident 23, taken by the Administrator, dated 7/29/25, indicated the resident stated the male resident was touching her and sometimes massaged her shoulder or between her shoulder blades. The resident indicated it started about two weeks ago, made her uncomfortable, but she was not scared of the male resident. She stated the resident had not said anything sexual to her. A statement from the male resident, dated 7/29/25, indicated he stated he did not mean anything by touching or rubbing Resident 23's shoulders. The resident stated some people liked that, but he would need to ask before doing that. A statement from Resident 23, taken by the SSD, dated 7/29/25, indicated the resident was asked if she felt like the male resident rubbing her shoulders felt like sexual abuse or if she felt like the resident was making a sexual advance towards her. Resident 23 indicated, Yes, because in the past others would do that and one thing would lead to another. During an interview, on 7/30/25 at 1:56 p.m., the Administrator indicated any abuse allegation should have been reported to her immediately. If she was not in the facility then the staff should have called her. The QMA should have called the Administrator and notified her of the allegation, instead of only reporting it to the nurse. On 7/28/25 at 2:00 p.m., the Administrator provided a document titled, Abuse Prevention Program, dated 10/22/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.The following procedures shall be implemented when an employee or agent becomes aware of abuse.or of an allegation of suspected abuse.of a resident.Procedure.III. Reporting.Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. The Administrator is the Abuse Coordinator. 3.1-28(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment had been coded correctly for 1 of 19 resident MDS assessments reviewed (Resident 46). Findings include:Resident 46's record was reviewed on 7/31/25 at 2:23 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hypertensive heart disease (a condition where high blood pressure over a long period damages the heart, leading to various heart problems) and congestive heart failure (when the heart does not pump blood efficiently as it should). The census indicated the resident began hospice services on 3/13/25. A care plan indicated the resident wished for hospice services. Interventions included, but were not limited to, hospice services as ordered. A quarterly MDS assessment, dated 6/17/25, indicated the resident received hospice services. The assessment lacked documentation of a terminal prognosis. During an interview, on 7/31/25 at 2:47 p.m., the MDS Coordinator indicated the resident's prognosis had been coded incorrectly. The standard was that the rules from the RAI (Resident Assessment Instrument) would be followed when documenting information about the resident on the MDS assessment. On 8/1/25 at 9:47 a.m., the Director of Nursing (DON) provided a copy of Section J of the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual, dated October 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .J1400 Prognosis.Coding Instructions.Code 1, yes: if the medical record includes physician documentation: .2) the resident is receiving hospice services. 3.1-36(a)(6)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were invited to attend quarterly care plan meetings for 2 of 3 residents reviewed for care plan meetings (Residents 19 and 8), and failed to ensure code status care plans were consistent with the resident's advanced directive for 1 of 19 residents' care plans reviewed (Resident 7). Findings include: 1. On [DATE] at 1:33 p.m., during an interview, Resident 19 indicated she had not attended a care plan meeting and had not been asked to attend one. On [DATE] at 11:35 a.m., during interview the Social Service Director (SSD) indicated she invited residents to attend care plan meetings and documented the meeting and if the resident attended the meeting. Attendance was included in the meeting documentation. On [DATE] at 10:35 a.m., the medical record of Resident 19 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but not limited to, hypertension (high blood pressure) and dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A Minimum Data Set (MDS) assessment, dated [DATE], indicated that the resident had limited cognition. The record lacked documentation of quarterly care plan meeting or of the resident attending a quarterly care plan meeting on the following months, 3/2024, 9/2024, 12/2024 and 6/2025. A care plan note, dated [DATE], indicated that the resident attended a care plan meeting. 2. On [DATE] at 9:59 a.m., during an interview, Resident 8 indicated she did not remember attending a care plan meeting to discuss care needs and concerns. On [DATE] at 10:45 a.m., the medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included, but was not limited to, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (high blood pressure). A Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. Review of the medical record indicated the record lacked documentation of a quarterly care plan meeting or of resident attending a quarterly care plan meeting on the following months: 7/2024, 10/2024, 1/2025, and 7/2025. Care plan meeting notes, dated [DATE] and [DATE], indicated the resident attended a care plan meeting. On [DATE] at 9:00 a.m., the Administrator provided a document titled, Baseline Care Plan Assessment/Comprehensive Care Plans, dated [DATE], and indicated it was the policy currently being used by the facility. The policy indicated, .6. The facility Social Services Director or designee will notify the resident of their scheduled Care Plan Conference and will invite and encourage the resident to attend. This notification will continue for any subsequent Care Plan Conferences. These notifications will be documented for reference.9. The Comprehensive Care Plans will be reviewed and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated every quarter at a minimum. 3. Resident 7's record was reviewed on [DATE] at 9:14 a.m. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had severe cognitive impairment. A Physician's Orders for Scope of Treatment (POST) (a document that outlines a patient's preferences for treatment particularly at the end of life) form, dated [DATE], indicated the resident wanted cardiopulmonary resuscitation (CPR) to be performed if she was found in cardiac arrest. A care plan, initiated on [DATE], indicated POST form-full intervention including life support measures. A care plan, initiated on [DATE], indicated POST form-comfort measures, allow natural death. During an interview, on [DATE] at 10:26 a.m., the Director of Nursing (DON) indicated she was not sure why there were two conflicting care plans for the resident's POST form. The care plan should have been consistent with what the resident indicated in the POST form. On [DATE] at 10:39 a.m., the DON provided a document titled, Baseline Care Plan Assessment/Comprehensive Care Plans, last revised on [DATE], and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. 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. 3.1-35(a) 3.1-35(c)(2)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to ensure urinary tract infections (UTIs) were treated in a timely manner after receiving urinary culture results for 2 of 2 residents reviewed for UTI (Residents 3 and 7). Findings include: 1. Resident 3's record was reviewed on 7/29/25 at 11:27 a.m. An admission Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident was cognitively intact. A nursing progress note, dated 7/3/25, indicated the resident's daughter was concerned about how much the resident was sleeping and noted increased confusion. A new physician's order for a urinalysis (UA) culture and sensitivity (C&S) was received. A nursing progress note, dated 7/6/25, indicated a urine sample was obtained from the resident and sent to the hospital for a UA C&S. A UA C&S indicated the report was finalized on 7/8/25. The report indicated a colony count greater than 100,000 proteus mirabilis (bacteria) The C&S did not include ciprofloxacin (antibiotic) as an antibiotic that was tested for efficacy against the bacteria. The C&S indicated the bacteria was susceptible to Bactrim double strength (DS) (antibiotic). A nursing progress note, dated 7/9/25, indicated the UA C&S results were received from the lab. The results were faxed to the physician. The note lacked documentation an antibiotic order was obtained at that time. A nurse practitioner (NP) progress note, dated 7/11/25, indicated the NP was at the facility and reviewed the UA C&S results. The NP gave an order for ciprofloxacin for five days for UTI. The note lacked documentation of why ciprofloxacin was ordered despite it not being included on the C&S. An NP order, dated 7/11/25, indicated ciprofloxacin 250 milligrams (mg), 1 tablet by mouth every 12 hours for 5 days, for UTI. A nursing progress note, dated 7/15/25, indicated the physician's office called and ordered Bactrim DS twice daily for five days for UTI and discontinued the ciprofloxacin after the dose that evening. A physician's order, dated 7/16/25, indicated Bactrim double strength (DS) (antibiotic) 800-160 mg, 1 tablet by mouth, twice daily for 5 days, for UTI. During an interview, on 7/30/25 at 1:24 p.m., the Director of Nursing (DON) indicated the UA C&S was faxed to the physician's office on 7/9/25, but the physician was on vacation. The NP came into the facility on 7/11/25 and ordered ciprofloxacin. The DON indicated she was not sure why the NP ordered an antibiotic that was not included on the C&S. The physician reviewed the UA C&S on 7/15/25, when he returned from vacation. The physician changed the antibiotic upon his review. It should have been followed up on before 7/15/25. 2. Resident 7's record was reviewed on 7/31/25 at 9:14 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/6/25, indicated the resident had a severe cognitive impairment. A urinalysis (UA) culture and sensitivity (C&S) report indicated it was finalized on 7/16/25. The report indicated a colony count greater than 100,000 Escherichia coli (E. coli) (bacteria) in the urine. The C&S did not include Macrobid (antibiotic) as an antibiotic that was tested for efficacy against the bacteria. A nursing progress note, dated 7/18/25, indicated the C&S report was received and faxed to the physician. The note lacked documentation physician's orders were obtained related to the UA C&S at that time. A Medication Administration Record (MAR), dated July 2025, included the following physician's orders. A physician's order, dated 7/21/25 and discontinued on 7/22/25, indicated Macrobid 100 milligrams (mg) by mouth, twice daily for UTI, for 7 days. The MAR indicated the medication was administered on evening shift of 7/21/25. A physician's order, dated 7/22/25 and discontinued on 7/22/25, indicated Macrobid 100 mg by mouth, twice daily for UTI, for 7 days. The MAR indicated an administration was scheduled for day shift, on 7/22/25, but lacked documentation the medication was administered or refused. A physician's order, dated 7/22/25 and discontinued on 7/24/25, indicated Macrobid 100 milligrams (mg) by mouth, twice daily for UTI, for 7 days. The MAR indicated the medication was administered once on 7/22/25 and twice on 7/23/25. A physician's order, dated 7/23/25, indicated contact isolation precautions for E. coli in the urine, until 7/29/25. A physician's order, dated 7/24/25, indicated Macrobid 100 milligrams (mg) by mouth, twice daily for UTI, for 7 days. The MAR indicated the medication was administered once on 7/24/25, twice on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/25/25, 7/26/25, 7/27/25, 7/28/25, 7/29/25, 7/30/35, and once on 7/31/25. The record lacked documentation the resident's UTI was treated prior to 7/21/25. Current care plans indicated the resident was on isolation precautions due to E.coli in the urine and received an antibiotic for a UTI. During an interview, on 7/31/25 at 10:26 a.m., the Director of Nursing (DON) indicated she was not able to find any additional information regarding the resident's antibiotic and why it was not ordered until 7/21/25. The physician should have been notified immediately of UA C&S results that required an antibiotic. If the physician ordered something that was not included on the C&S then the nurse should have told the physician the antibiotic was not included on the C&S to ensure it was the correct order. Although the physician may have wanted to continue the Macrobid as he ordered, the conversations should have been documented. On 7/30/25 at 1:48 p.m., the DON provided a document titled, Guidelines for Lab Scheduling/Tracking, dated 9/1/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Intent: it is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that ordered lab work is obtained and results are received and reported timely.Procedure.6. The Charge Nurse will monitor the scheduled labs daily to check to ensure that any collected lab results are received timely as well as to confirm that received results are reported to the physician.and that any orders received related to the lab results are carried out. Critical lab results will be reported to the physician upon receipt. On 7/30/25 at 2:16 p.m., the DON provided a document titled, Guidelines For Addressing/Managing Urinary Tract Infections-UTIs, last revised on 9/26/24, and indicated it was the policy currently being used by the facility. The policy indicated, .What are some complications that can present related to UTIs? When treated promptly and appropriately, lower urinary tract infections rarely lead to complications. However, left untreated, UTIs can cause multiple serious health problems.Additional Information: It is imperative that staff be made aware of signs/symptoms of UTIs so that UTIs can be identified and addressed and treatment for resolution be implemented immediately. 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure proper storage of respiratory equipment for 2 of 3 reviewed for respiratory care (Residents 51 & 46). Findings include:1. On 7/28/25 at 11:28 a.m., Resident 51's unbagged nebulizer mask was observed on top of a blanket and other linens on the resident's chair next to her bed. The nebulizer machine was sitting on the chair cushion. On 7/28/25 at 1:15 p.m., Resident 51's unbagged nebulizer mask was observed on top of a blanket and other linens on the resident's chair next to her bed. There was also a metal lid next to the nebulizer mask from the resident's lunch tray. On 7/29/25 at 9:30 a.m., Resident 51's unbagged nebulizer mask was observed on top of a blanket and other linens on the resident's chair next to her bed. On 7/30/25 at 10:10 a.m., Resident 51's unbagged nebulizer mask was observed sitting on top of the chair cushion next to her bed. The medication chamber was detached from the mask and was in contact with the floor. During an interview, on 7/30/25 at 10:16 a.m., Resident 51 indicated she received breathing treatment several times a day. She indicated that staff would prepare the breathing treatment for her and would turn off the machine when it was completed; she had noticed that staff don't always place the nebulizer mask in a bag after the treatment was completed. Resident 51's record was reviewed on 7/30/25 at 11:42 a.m. The profile indicated the resident diagnoses, included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of disease that cause airflow blockage and breathing-related problems), and chronic respiratory failure with hypoxia (chronic impairment of gas exchange between the lungs and the blood causing hypoxia [inadequate supply of oxygen]). A quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 4/8/25, indicated the resident displayed complications with gas exchange due to chronic respiratory failure and received oxygen. Interventions included but were not limited to, monitor that nasal cannula and or mask is properly positioned, elevate head of bed to facilitate breathing, and notify MD (medical doctor) of any changes. A physician order, dated 4/24/25, indicated albuterol sulfate nebulization solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier); 1.25mg (milligrams)/3ml (milliliters). One vial orally via nebulizer 4 times a day. During an interview, on 7/31/25 at 1:37 p.m., Licensed Practical Nurse (LPN) 17 indicated after the resident had completed their nebulizer treatment, the nurse was to rinse out the nebulizer equipment and then place it in a plastic bag for storage while not in use. 2. During the initial pool observation, on 7/28/25 at 10:52 a.m., Resident 46's nebulizer (a device that converts liquid medicine into a fine mist, allowing it to be inhaled directly into the lungs) mask was observed unbagged and sitting on her bedside table. At the same time, the resident indicated she had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not had a nebulizer treatment on this date. Her last treatment was the day prior. During a random observation, on 7/30/25 at 10:35 a.m., the resident's nebulizer mask was observed unbagged and sitting on her bedside table. During a random observation, on 7/30/25 at 2:41 p.m., the resident's nebulizer mask was observed unbagged and sitting on her bedside table. During a random observation, on 7/31/25 at 09:04 a.m., the resident's nebulizer mask was observed unbagged and sitting on her bedside table. Resident 46's record was reviewed on 7/31/25 at 2:23 p.m. The profile indicated the resident's diagnoses included, but were not limited to, congestive heart failure (when the heart isn't pumping blood as efficiently as it should). A quarterly Minimum Data Set (MDS) assessment, dated 6/17/25, indicated the resident had no cognitive deficit and received respiratory therapy treatments. A care plan indicated the resident was at risk of experiencing wheezing. The care plan lacked documentation of any medication orders or procedure for treatment. A physician's order, dated 5/6/25, indicated to administer one vial of albuterol sulfate nebulization solution (used to relax the muscles around the airways in the lungs, making it easier to breathe) 2.5 milligrams (mg) per 3 milliliters (ml) every 24 hours as needed for shortness of breath. The July 2025 Medication Administration Record (MAR) indicated the resident had received nebulizer treatments on 7/5/25, 7/7/25, and 7/31/25. During an interview, on 7/31/25 at 11:17 a.m., Licensed Practical Nurse (LPN) 7 indicated nebulizer equipment should be cleaned and then placed into a dated bag when not in use. During an interview, on 7/31/25 at 11:20 a.m., the Director of Nursing (DON) indicated the nebulizer masks should be placed in a bag when not in use. On 7/31/25 at 12:11 p.m., the DON provided an undated document, titled, Aerosolized Medication Therapy, and indicated it was the policy currently used by the facility. The policy indicated, .Procedure.16. When finished, place the nebulizer in a labeled bag with patient name and date. 3.1-47(a)(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's dialysis (medical treatment that helps remove waste products and excess fluid from the blood when a person's kidneys are not functioning properly) access site was accurately assessed for 1 of 1 residents reviewed for dialysis (Resident 42). Findings include:Resident 42's record was reviewed on 7/31/25 at 11:39 a.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, stage four chronic kidney disease (severe kidney disease with significantly reduced kidney function) and dependence on renal dialysis. An admission Minimum Data Set (MDS) assessment, dated 7/10/25, indicated the resident was cognitively intact. A medication administration record (MAR), dated July 2025, included a physician's order, dated 7/7/35, to maintain the resident's dialysis access site. The order indicated check for blood flow by feeling for a pulse or rushing sensation (thrill) on the access site (an assessment technique to ensure blood is flowing to a fistula [surgically created connection between a vein and artery used for dialysis]). The MAR indicated the assessment was completed twice daily from 7/7/25 to 7/31/25. The MAR, dated July 2025, included a physician's order, dated 7/4/25, to monitor the resident's Permacath (tunneled dialysis catheter) site to the right upper chest every shift for complications. The Permacath was only to be accessed by dialysis, and the dressing was changed by dialysis. The MAR indicated the assessment was completed twice daily from 7/4/25 to 7/31/25. Current care plans indicated the resident had a Permacath to the right upper chest and received dialysis three times weekly. During an interview, on 7/31/25 at 12:37 p.m., Resident 42 indicated she had a Permacath in her chest/neck area as an access for her dialysis. The dialysis staff provided the care for the access site, and the facility staff did not normally do anything with it or look at it. The resident indicated she would notify the facility staff if there was an issue with the access site. The resident did not have a fistula for dialysis. During an interview, on 7/31/25 at 12:39 p.m., Licensed Practical Nurse (LPN) 17 indicated the resident had a Permacath for the dialysis access site. The order to assess the fistula should not have been in place because the resident did not have a fistula. During an interview, on 7/31/25 at 1:05 p.m., the Director of Nursing (DON) indicated the resident had Permacath for the dialysis access site. The order to assess the fistula was put in by mistake. The nurses should not have documented they assessed a fistula because the resident did not have one. On 7/31/25 at 1:16 p.m., the DON provided an undated document titled, Community Hemodialysis, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure coordination of care for residents requiring hemodialysis in the community. Policy: 1. All residents that are admitted to the facility with needs for hemodialysis will have coordination of services between the facility and the hemodialysis unit prior to admission. 3.1-37(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview, the facility failed to ensure behavior monitoring was completed for 1 of 5 residents reviewed for unnecessary medications (Resident 22).Findings include:Resident 22's record was reviewed on 7/29/25 at 11:31 a.m. The profile indicated the resident's diagnoses included, but were not limited to, metabolic encephalopathy (a condition where the brain's function is impaired due to a metabolic or chemical imbalance in the body), Parkinson's disease (a progressive neurological disorder that affects movement), and hallucinations unspecified (when someone experiences something with their senses [see, hear, smell, taste, or feel] that isn't actually there). A quarterly Minimum Data Set (MDS) assessment, dated 4/19/25, indicated the resident had severe cognitive deficit, had no documented behaviors, and received hospice services. A care plan was observed that indicated the resident was at risk for hallucinations and delusions (a fixed, false belief that is not based on reality and is held with strong conviction, despite evidence to the contrary). Interventions included, but were not limited to, monitor for effectiveness of medications and interventions. A physician's order, dated 11/15/23, indicated to monitor for the behaviors of hallucinations and delusions every shift. Hospice nurse progress notes, dated 3/3/25 and 3/19/25, indicated the resident continued to have frequent hallucinations daily. The March 2025 Treatment Administration Record (TAR) lacked documentation of the resident having any behaviors for the entire month. Hospice nurse progress notes, dated 4/9/25 and 4/30/25, indicated the resident continued to have frequent hallucinations daily. The April 2025 TAR lacked documentation of the resident having any behaviors for the entire month. Hospice nurse progress notes, dated 5/2/25, 5/5/25, 5/7/25, and 5/14/25, indicated the resident continued to have frequent hallucinations daily. The May 2025 TAR lacked documentation of the resident having any behaviors for the entire month. Hospice nurse progress notes, dated, 6/4/25, 6/11/25, and 6/27.25, indicated the resident continued to have frequent hallucinations daily.The June 2025 TAR lacked documentation of the resident having behaviors on the dates documented by the hospice nurse. The TAR documented behaviors on day shifts of 6/17/25, 6/18/25, 6/23/25, and 6/24/25, and on the night shifts of 6/17/25, 6/22/25, 6/23/25, and 6/24/25. The dates lacked documentation of what interventions had been attempted for the behaviors. Hospice nurse progress notes, dated, 7/16/25, 7/18/25, 7/23/25, and 7/25/25, indicated the resident continued to have frequent hallucinations daily. The July 2025 TAR lacked documentation of the resident having any behaviors for the entire month. Review of the resident progress notes, dated March 2025 through July 2025, lacked documentation of any hallucinations by the facility nursing staff. Review of the facility's interdisciplinary team (a group of professionals from different fields who work together to achieve a common goal, typically by sharing their expertise and collaborating on a solution) progress notes, from July 2024 through July 2025, lacked documentation of any hallucination or delusions by the resident. During an interview, on 7/30/25 at 8:55 a.m., Licensed Practical Nurse (LPN 7) indicated all nurses were responsible to complete the behavior tracking on the TAR each shift. During an interview, on 7/30/25 at 9:46 a.m., Hospice Registered Nurse (RN) 8 indicated she had witnessed the resident having visual hallucinations on a few of her visits. She had reported the incidents to the nursing staff of the facility. She was not sure if the facility nurses documented the reported behaviors in the resident's medical record or not. During an interview, on 7/30/25 at 9:52 a.m., Hospice Aide 9 indicated she worked with the resident two days a week. She had observed the resident hallucinating at times. She would report the incidents to both her Hospice nurse and to the facility nurse. She was unsure what the facility did to follow up on the report. During an interview, on 7/30/25 at 9:55 a.m., Hospice Aide 10 indicated she also came to the facility two days a week to assist the resident with her bathing and other needs. She had observed the resident hallucinating and had reported to both her Hospice nurse and to the facility nurse. She was unsure what the facility did to follow up on the report. During an interview, on 7/30/25 at 10:10 (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., Certified Nurse Aides (CNAs) 11 and 12 indicated the resident still hallucinated frequently. CNA 11 indicated she was not sure where she was to document behaviors in the medical record. CNA 12 indicated the nurses were responsible for documenting behaviors. Both CNAs indicated they would report any behaviors that were observed to the nurse. During an interview, on 7/30/25 at 10:50 a.m., the Director of Nursing (DON) indicated the CNAs were not responsible to document the behaviors they witness. They were to report the behaviors to the nurse who was responsible for documenting the behavior. On 7/30/25 at 10:37 a.m., the DON provided a document, dated 8/18/23, titled, Guidelines for Behavior Management Meetings Psychotropic Medication, and indicated it was the policy currently being used by the facility. The policy indicated, .Roles-Responsibilities.Nursing.2. Monitors for presence of target behaviors on daily basis and documenting same. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Waters of Sullivan Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 505 W Wolfe St Sullivan, IN 47882	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 1 of 2 medication storage rooms reviewed for medication storage. Findings include:On 7/30/25 at 1:45 p.m., the East wing medication storage room contained an undated and opened multi use vial of Tubersol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution.During an interview, on 7/30/25 at 1:44 p.m., Licensed Practical Nurse (LPN) 14 indicated Tubersol solution was good for 30 days once it had been opened. She would dispose of the vial since it was not labeled with an open date, and she wasn't sure how long it had been in the refrigerator.During an interview, on 7/30/25 at 1:54 p.m., LPN 7 indicated Tubersol solution was good for 30 days once it had been opened and should be dated when opened.On 7/30/25 at 2:17 p.m., the Director of Nursing (DON) provided a document, dated July 2024, titled, Medication Storage in the Facility, and indicated it was the current policy used by the facility. The policy indicated, .Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations On 7/30/25 at 2:34 p.m., the DON provided an undated document, titled, Tuberculin Purified Protein Derivative, and indicated it was the current policy used by the facility. The policy indicated, .A vial of Tubersol which has been entered and in use for 30 days should be discarded. Do not use after expiration date.3.1-25(j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Sullivan Nursing Facility, The	505 W Wolfe St Sullivan, IN 47882

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the required staff hours posting was posted for Saturday, Sunday, and Monday during 1 of 5 staff posting observations. Findings include:During a continuous observation, upon entrance to the facility, on 7/28/25 (a Monday) from 7:30 a.m. to 7:59 a.m., no daily staff hours posting was observed in the facility. There was no daily staff hours posting from the weekend, or the current day, observed at either nurse's station or in the main lobby. During an interview, on 7/31/25 at 2:41 p.m., the Director of Nursing (DON) indicated she hung up Monday's (7/28/25) daily staff posting when she arrived at the facility. She was not in the facility between 7:30 a.m. and 7:59 a.m. During an interview, on 7/31/25 at 2:45 p.m., the DON indicated she was not sure why the weekend and Monday daily staff posting sheets were not hung up prior to her arrival on Monday (7/28/25). They were left for the staff over the weekend, and the nursing supervisor or floor staff should have hung them up. On 7/31/25 at 2:49 p.m., the DON provided a document titled, Guidelines for.Staffing Posting Requirement, dated 7/24/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: It is the policy of the facility, in cooperation with Medicare/Medicaid Services,.to comply with the requirement of daily posting of nursing staff in the facility. Procedure: 1) SNFs [skilled nursing facilities] and NFs [nursing facilities] must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by licensed and licensed nursing staff who are directly responsible for resident care.