STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Meadows	300 E Prairie St Warsaw, IN 46580

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure cleaning chemicals were stored securely on the memory care unit. This failure resulted in a resident with Alzheimer's Disease and dementia that accessed an unlocked water conditioner closet, handling and ingesting drain cleaner. The resident suffered pain, nausea, vomiting and required emergency room services, that included undergoing anesthesia for a gastro-intestinal (GI) endoscopy procedure to evaluate for damages. This affected 1 of 3 residents reviewed for accidents, (Resident B). The deficient practice was corrected on 7/11/25, prior to the start of the survey, and was therefore past noncompliance.Finding includes: Review of a facility reported incident, #633, submitted to the Indiana State Department of Health on 7/10/25, indicated on 7/10/25 at 1:30 A.M., Resident B was found vomiting in the Memory Care hallway and the vomit allegedly had a smell of bleach. The resident was then assisted to his room by staff and no distress was noted by the staff. The staff completed a safety sweep of the hallway and could not locate any chemicals. The resident's physician and the Poison Control Center were notified and it was recommended the resident go to the emergency room (ER) for evaluation and treatment.During an interview on 7/22/25 at 3:39 P.M., CNA 1 indicated she had worked on the memory care unit overnight on 7/10/25 and had taken a break off the unit. CNA indicated upon her return from break, she looked down the straight hall in the memory care unit to the water conditioning closet and saw the back part of Resident B's wheelchair sticking out of the water conditioning room. CNA 1 indicated she went to the resident, pulled him back from the closet in his wheelchair and noted he was holding a bottle of Liquid Plumber (drain clearner) in his hand. CNA 1 indicated she asked the resident what he had been doing and he pointed to his mouth. CNA 1 indicated she took the bottle from Resident B and called for assistance from Qualified Medication Aide (QMA) 3, who was coming down the hall at that time. CNA 1 indicated the resident then began gagging and by the time she got him to the doorway of his room, the resident had begun vomiting. CNA 1 indicated QMA 3 called for Registered Nurse (RN) 2, who was on the memory care unit at that time, and RN2 had arrived to Resident B's room and assessed him. CNA 1 indicated the resident continued to vomit and indicated his mouth and his stomach hurt. CNA 1 indicated RN 2 had notified Resident B's physician and the Poison Control Center immediately.During an interview, on 7/23/25 at 10:28 A.M with RN 2, she indicated on 6/10/25 at 1:41 A.M., she was on the memory care unit checking glucose monitors when CNA 1 called her to Resident B's room. She indicated the resident was seated in his wheelchair, in the doorway of his room with a trash can in his lap, actively vomiting. RN2 indicated CNA 1 had reported that she thought the resident had drank something from the water conditioner closet but the CNA indicated she did not know what Resident B had drank. RN 2 indicated she called the Director of Nursing to get the code to the water conditioner closet and there she found a bottle of Draino (drain cleaner). RN 2 indicated she looked at the bottle label , where it instructed not to induce vomiting if ingested, but the resident had already vomited by the time she had read the label . RN 2 indicated when she knew what the resident had ingested, she had called the Nurse Practitioner and instructed QMA 3 to call the Poison Control Center, thus having both parties on the phone at the same time. RN 2 indicated the Poison Control Center had recommended sending the resident to the ER immediately. RN 2 indicated she then called 911 immediately and had sat with the resident until the Emergency Medical Services (EMS) arrived. RN 2 indicated Resident B had complained of stomach pain while they had waited for EMS and when EMS assessed the resident, he had also complained of throat pain.On 7/22/25 at 3:19 P.M., Resident B's clinical record was reviewed. The resident had diagnoses that included, but were not limited to dementia, depression, and Alzheimer's Disease. Review of Resident B's most recent comprehensive Minimum Data Set (MDS), dated [DATE] for an Annual Assessment, indicated the resident was severely cognitively impaired, experienced delusions and misconceptions that were contrary to reality and demonstrated no unwanted behaviors. Resident B had no range of motion impairments to his arms or legs but required a wheelchair for locomotion.An Elopement/Wander Risk Evaluation, dated 5/17/25 for a quarterly review, indicated Resident B was at risk for elopement and wandering due to a forgetful and short attention span, dementia with psychosis, and independence with his wheelchair. Resident B utilized a wander guard (device worn on wrist or ankle to magnetically lock exit doors when resident came within close proximity of the doors). Resident B's Nursing Progress Notes, on 7/10/2025 at 1:45 A.M., completed by Registered Nurse (RN) 2, indicated she had been called to Resident B's room where the resident was seated in his wheelchair