

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Warsaw Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview and record review, the facility failed to ensure a resident with orders for G-tube feedings (a method of delivering nutrition directly into the stomach using a Gastrostomy tube), post feed flushes, G-tube bag and tubing changes, and G-tube placement checks, were completed and documented by licensed nursing staff. Some QMAs (Qualified Nursing Aide) documented that they had administered G-tube feeding, post feed flushes, G-tube bag and tubing changes, and G-tube placement checks, which was outside of the QMAs' Scope of Practice, for 1 of 1 residents reviewed for G-tube feeding, (Resident B). Finding includes: Resident B's clinical record was reviewed on 7/21/26 at 1:07 P.M. The residents' diagnoses included but were not limited to dysphagia (difficulty or discomfort in swallowing food and liquids), gastrostomy, convulsions, and history of traumatic brain injury. The residents' Physician Orders included but were not limited to: NPO (Nothing by mouth), enteral feed (G-tube), Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 calories at 110ml per hour by G-tube for 12 hours a day. Turn the pump on at 5:00 P.M., and turn the pump off when the total of 1320 ml has infused. The start was 10/9/25 and the order was discontinued on 6/30/26. Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 calories at 83ml per hour by G-tube for 16 hours a day. Turn the pump on at 5:00 P.M., and turn the pump off when the total of 1328 ml has infused. The start date was 6/30/26 and the order was discontinued on 7/9/26. Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 calories at 83ml per hour by G-tube for 16 hours a day. Turn the pump on at 5:00 P.M. and turn the pump off when the total of 1328 ml has infused. The start date was 7/9/26 and was discontinued on 7/15/26. Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 cal at 83mL per hour by G-tube for 16 hours a day. Turn the pump on at 5:00 P.M. and turn the pump off when the total of 1328 ml has infused. The start date was 7/16/26 and was discontinued on 7/21/26. Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 cal at 83mL per hour by G-tube for 16 hours a day. Turn the pump on at 5:00 P.M. and turn the pump off when the total of 1328 ml has infused. To be completed by LPN or RN only. The start date was 7/21/26 and ongoing. After stopping the G-tube feed, flush with 60 ml of warm water to prevent clogging. Tube should be clear after flush and formula flushed out of tube one time a day for flush feeding tube after stopping feed. With a start date of 6/7/25 and ongoing. Check the G-tube placement by auscultating air passage and aspirating contents four times a day Document amount of residual, with a start date of 9/3/25 and discontinued on 7/21/26. Check tube placement by auscultating air passage and aspirating contents four times a day for G-tube, LPN or RN must complete this only, document amount of residual. Hold if residual is greater than 150cc. Notify provider. The start date was 7/21/26 and ongoing. Change G-tube bag and tubing every night. Date and initial directly on the tubing. The start date was 3/8/25 and ongoing. Resident B's EMAR (Electronic Medication Administration Record), (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155566 If continuation sheet Page 1 of 3

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated from 4/1/26 to 7/22/26 three QMAs documented that they had administered the following:Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 calories at 110ml per hour by G-tube for 12 hours a day. Turn the pump on at 5:00 P.M., and turn the pump off when the total of 1320 ml has infused. And Enteral Feed two times a day for nutritional support and NPO status related to dysphagia. Give Jevity 1.5 cal at 83mLper hour by G-tube for 16 hours a day. Turn the pump on at 5:00 P.M. and turn the pump off when the total of 1328 ml has infused.Documented as started by QMA 3 at 5:00 P.M., on 4/11/26, 4/12/26, 4/15/26, 4/25/26, 4/26/26 4/29/26, 5/19/26.Documented as started by QMA 4 at 5:00 P.M., on 6/10/26, 6/25/26.Documented as started by QMA 5 at 5:00 P.M., on 5/21/26, 5/23/26, 5/24/26, 5/28/26, 6/1/26, 6/8/26, 6/11/26, 6/15/26, 6/24/26.Documented as stopped by QMA 3 at 5:00 A.M., on 5/9/26, 5/21/26, 5/24/26, 5/25/26, 5/27/26, 6/2/26, 6/3/26, 6/4/26, 6/10/26, 6/14/26, 6/16/26,6/18/26, 6/23/26.Documented as stopped by QMA 4 at 9:00 A.M. on 7/9/26.Documented as stopped by QMA 5 at 9:00 A.M. on 7/4/26.After stopping the G-tube feed, flush with 60 ml of warm water to prevent clogging. Tube should be clear after flush and formula flushed out of tube one time a day for flush feeding tube after stopping feed.Documented as done by QMA 2 at 5:00 A.M., on 5/9/26, 5/21/26, 5/24/26, 5/25/26, 5/27/26, 6/2/26/6/3/26, 6/4/26, 6/10/26, 6/14/26, 6/16/26, 6/18/26, 6/23/26, 7/2/26.Documented as done by QMA 4 at 9:00 A.M. on 7/9/26.Documented as done by QMA 5 at 9:00 A.M. on 7/6/26, 7/7/26, 7/8/26.Check the G-tube placement by auscultating air passage and aspirating contents four times a day Document amount of residual.Documented as done by QMA 3 at 5:00 A.M., on 5/9/26,5/21/26, 5/2/26, 5/25/26, 5/27/26, 6/2/26,6/3/26, 6/4/26, 6/10/26, 6/14/26, 6/16/26, 6/18/26, 6/23/26.Documented as done by QMA 3 at 8:00 A.M., on 4/11/26, 4/12/26, 4/15/26, 4/25/26, 4/26/26, 4/29/26, 5/19/26.Documented as done by QMA 3 at 5:00 P.M., on 4/11/26, 4/12/26, 4/15/26, 4/25/26, 4/26/26, 4/29/26, 5/19/26.Documented as done by QMA 3 at 8:00 P.M., on 5/8/26, 5/20/26, 5/23/26, 5/24/26, 6/1/26, 6/2/26, 6/3/26, 6/13/26, 6/15/26, 6/17/26.Documented as done by QMA 4 at 8:00 A.M., on 5/28/26, 6/10/26, 6/12/26, 6/25/26.Documented as done by QMA 4 at 5:00 P.M., on 6/10/26, 6/23/26, 6/25/26.Documented as done by QMA 4 at 8:00 P.M., on 6/23/26, 6/29/26.Documented as done by QMA 5 at 8:00 A.M., on 5/21/26, 5/23/26, 5/24/26, 5/27/26, 5/29/26, 5/29/24, 6/11/26, 6/15/26, 6/24/26.Documented as done by QMA 5 at 5:00 P.M., on 5/21/26, 5/23/26, 5/24/26, 5/28/26, 6/1/26, 6/8/26, 6/11/26, 6/15/26, 6/24/26.Documented as done by QMA 5 at 8:00 P.M., on 5/21/26, 6/12/26.Change G-tube bag and tubing every night. Date and initial directly on the tubing.Documented as done by QMA 3 at 5:00 P.M., on 4/11/26, 4/12/26,4/15/26, 4/25/26, 4/26/26, 4/29/26, 5/19/26.Documented as done by QMA 4 at 5:00 P.M., on 6/10/26, 6/23/26, 6/25/26, 7/9/26.Documented as done by QMA 5 at 5:00 P.M., on 5/21/26, 5/23/26, 5/24/26, 5/28/26, 6/1/26, 6/8/26, 6/11/26, 6/15/26, 7/4/26.During an interview on 7/21/26 at 1:48 P.M., the Administrator indicated all nursing staff had been educated on 6/26/26, that starting and stopping G-tube feedings, flushing post feeding, checking for G-tube placement, and changing bag and tubing was out of the QMAs' scope of practice and they were not allowed to do or sign-off on those orders related to the G-tube feedings in residents' medication administration records (MAR). The Administrator indicated she was newer to the facility and had been at the facility approximately three months when she became aware of QMAs working outside of their scope of practice and had implemented an immediate change related to making sure staff discontinuing the activity (QMAs performing G tube related feedings, boluses and assessments) and educating nursing staff that QMAs were not allowed to administer G tube feedings. The Administrator indicated she and the Director of Nursing had only been in their positions at the facility for about three months and when they became aware that QMAs were working outside of their scope of practice, she (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the Director of Nursing had immediately educated the staff. During an interview with QMA 4, on 7/21/26 at 2:30 P.M., she indicated she had been instructed by the facility nursing staff that QMAs were allowed to completed the following: administer the G-tube feedings, check for proper G-tube placement, stop completed G tube feeds, and flush the tubing after feeding administration. QMA 4 indicated she had gone to a nursing staff, with her concern that those responsibilities were beyond her scope of practice and she had been told that QMAs were to do G-tube feedings at this facility. QMA 4 indicated the new Administrator and DON had finally realized that QMAs were being instructed to work out of their scope of practice and, at that time, the leadership had changed the orders indicating only licensed nursing staff could administer tube feedings, flushes, placement checks, and tubing changes. QMA 4 indicated every time she initialed the EMAR regarding G-tube feeding and all associated tasks, she had, in fact, provided those services and those signatures were not documentation errors but signatures denoting when QMA 4 had actually administered and/or performed duties outside of her scope of practice. QMA 4 indicated QMA 3 and QMA 5 had also administered G-tube feedings for Resident B, as well as flushes and tubing changes. During an interview, on 7/22/26 at 2:14, with QMA 5, she indicated she had hung Gtube feedings up and initiated their administration at the facility until a couple of months ago. She indicated the nurse on duty had instructed her to complete the task and would not come down and administer the feedings or flushes for her. The nurse had informed QMA 6 that at this facility, QMAs were supposed to start and stop gtube feedings and flush the tubing after the feedings and to check for placement. During an interview on 7/22/26 at 2:23 P.M., with RN 9, she indicated she had been working at the facility for over a year with the current leadership and under the previous leadership. While under the previous leadership, the QMAs had been instructed to hang G-tube feedings. RN 9 indicated she was not aware of all of the rules and regulations so she had followed the instruction of the leadership at the time. RN 9 indicated when the current administrator and DON came to the facility, they had notified nursing staff on 6/29/26 that QMAs were not allowed to check G-tube placement, start feeds, or change tubing. RN 9 indicated she had always signed when she administered any medications or treatments and if the G-tube feedings and treatments were documented by QMAs, then they were to ones who had completed the task. During an interview with RN 6, on 7/22/26 at 2:33 P.M., she indicated that prior to 6/29/26, QMAs regularly started G-tube feedings at the facility. She indicated until the new administrator became aware of QMAs working beyond their scope of practice and then nursing staff had received a message, through their nursing message system on 6/29/26, that QMAs were not allowed to do G-tube feedings, listen for G-tube placement, stop G-tube feeds, or flush after the feeding was completed. RN 6 indicated the previous DON had told nursing staff that G-tube feeding was in the QMAs' scope of practice. Review of Indiana Administrative Code, Title 412 - INDIANA HEALTH FACILITIES COUNCIL, Article 2 - QUALIFIED MEDICATION AIDES, Rule 1 - General Provisions Section 1-9 - Scope of practice Universal Citation: 412 IN Admin Code 1-9, Authority: IC 16-28-1-7; IC 16-28-1-11, dated 6/25/25, and found on line at https://regulations.justia.com/states/indiana/title-412/article-2/rule-1/section-9/, indicated G-tube feedings, flushes, placement checks, and tube and bag changes were not included in the QMAs' scope of practice. A policy titled Enteral Tube Feeding via Syringe (Bolus), dated 2001, was provided by the Administrator on 7/21/26 at 3:13 P.M., indicating it was the current facility policy. The policy indicated, .Documentation The person performing [G-tube] procedure should record the following information in the resident's medical record:.The name and title of the individual9s0 who performed the procedure. On 7/21/26 at 3:13 P.M., a policy regarding who was allowed to administer G-tube feeding and care was requested, but none was provided prior to the survey exit. This citation relates to Intake 3023414.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a).		