STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40339 Based on interview and record review, the facility failed to identify the number of staff needed for physical transfers and to ensure physical transfers were provided in a consistent manner for a resident who required extensive assistance for mobility for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B sustaining a fracture to her right ankle. Findings include: Review of a facility self reportable, dated 12/9/24, indicated on 12/7/24, Resident B had been transferred to bed from her wheelchair. The resident's right foot had not turned with the rest of her body. The report indicated a head-to-toe assessment had been completed with no injuries noted at that time. The resident had complained of discomfort to her right ankle and right lower leg, but had declined pain medication. Resident B continued to complain of pain throughout the night and early morning hours. The nurse indicated the right ankle had become swollen. An order for x-rays was provided and the result showed an acute ankle fracture. Resident B's clinical record was reviewed on 12/31/24 at 11:03 a.m. Diagnoses included right side hemiplegia and hemiparesis following stroke, peripheral vascular disease, difficulty in walking, major depressive disorder, and chronic pain syndrome. A current care plan, dated 12/22/21, and revised on 10/17/24, indicated Resident B required assistance extensive assistance with transfers. The care plan goal indicated the resident would feel secure with staff providing major support for transfer with some support. Interventions included to explain procedure and reassure safety. A current care plan, dated 11/30/21 and revised on 11/28/23, indicated Resident B required assistance with all activities of daily living (ADL) including transfers, since her recent medical event. The resident had right side hemiplegia following a stroke several years ago. She was unable to care for herself independently and had no voluntary movement to her upper and lower left side. She required extensive to dependent assistance of staff with all ADL tasks. Interventions included to encourage resident to participate in ADLs within her abilities and to assess and honor the resident's preferences. (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: 155571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER: Waters of Dunkirk Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 11563 W 300 S Dunkirk, IN 47336	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment, dated 11/26/24, indicated Resident B had moderate cognitive impairment, was dependent on staff for upper and lower body dressing, and required substantial/maximum assistance of staff (staff completes more than half of the effort) for transferring. The resident felt down, depressed or hopeless half or more days during assessment period. The resident displayed no behaviors or rejection of care, and received no scheduled or as needed pain medications during assessment period. An incident progress note, dated 12/7/24 at 2:06 p.m., indicated CNA 3 had transferred Resident B to bed following lunch. CNA 3 indicated to the nurse that when she was turning the resident the resident's ankle had not turned with the rest of the resident's body, causing pain to the resident's right ankle/lower leg. The resident's right lower extremity had no edema, bruising, or redness. The provider was notified with no new orders given at that time. A nursing progress note, dated 12/7/24 at 8:00 p.m., indicated the resident had requested a dose of pain medication. The resident had complained of pain to her right ankle and the nurse noticed the resident's foot and ankle had become swollen without discoloration present. A change of plan of care/orders progress note, dated 12/8/24 at 12:37 p.m., indicated the resident had complaints of pain and swelling her right ankle. An order was provided to obtain x-rays of the right ankle. An incident progress note, dated 12/8/24 at 3:55 p.m., indicated the x-ray result had been received and reported to the provider. The resident had a right acute fracture of the distal tibia. The medical doctor was notified and provided orders for resident to remain in bed. An incident progress note, dated 12/9/24 at 4:27 p.m., indicated new orders had been received for the resident to remain non-weight bearing to right lower extremity and to apply ice and elevation. Resident B was to be transferred to the orthopaedic walk-in clinic the following day. An Interdisciplinary Team (IDT) note, dated 12/10/24 at 10:53 a.m., indicated staff were transferring Resident B from the wheelchair to the bed. When staff and the resident turned, the resident's right foot had not turned with her body. The resident complained of pain and the CNA reported it to the nurse. The nurse completed a head-to-toe assessment. Resident B was found to have no visible injuries, but did complain of pain. The resident refused pain medication when offered. The complaint of pain remained throughout the night and swelling to area right ankle was observed. The resident's physician was updated and orders obtained for x-ray on 12/8/24. An x-ray was obtained with a finding of an acute fracture. The physician was again updated with multiple new orders, including the resident to be taken to [orthopaedic provider] when open on Monday. A current physician order, dated 12/8/24, included ketorolac tromethamine (to temporarily treat acute pain) 10 mg (milligram), one tablet every six hours as needed for moderate to severe pain. The resident had at least one dose daily since the fracture, with an average pain rating at 7 on a scale of 1-10. During a random observation, on 12/31/24 at 10:43 a.m., Resident B was lying in bed on her back, covered with a blanket. Her eyes were closed and her head was positioned to the left. The resident was dressed in a hospital gown. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/24 at 11:39 a.m., the ADON indicated Resident B was a two person assist for transfer prior to her fracture. CNA 3 had just finished her CNA class in June and had recently passed her certification. The ADON was unsure if CNA 3 referenced the CNA assignment sheets prior to providing care, but that was the expectation of staff. The ADON had since educated the staff regarding two person assists and that two staff must assist in care when indicated. The facility had no specific policy regarding staff assisted transfers or where to locate information on resident care needs. During a random observation, on 12/31/24 at 11:40 a.m., Resident B was lying in her bed on her back, covered with a blanket. Her eyes were closed and her head was positioned to the right. The resident was dressed in a hospital gown. During a telephone interview on 12/31/24 at 11:51 a.m., CNA 3 indicated she had been a CNA since the first week of November 2024. She was not aware that Resident B was a two person assist for transfers. She had witnessed staff transferring Resident B independently. She was unaware the facility had CNA Assignment Sheets. She was transferring Resident B and her foot usually slid with her body when turning her to her bed or chair, but this time, her right foot had not turned. The CNA reported it to the nurse as soon as she completed getting the resident settled in bed. During a random observation, on 12/31/24 at 1:10 p.m., Resident B was lying in her bed on her back, covered with a blanket. Her eyes were closed and her head was straight on her pillow. The resident was dressed in a hospital gown. During an interview on 12/31/24 at 1:48 p.m., Resident B indicated she hadn't been out of bed today because she just hadn't felt like it. She had a loss of appetite, but had not felt like an increase in depression or anything like that since her fracture. Staff had always transferred her with just one person and on this occasion, her foot just had not slid as usual. She had pain, but staff were good to provide her medication when she needs the medication. She felt more tired than usual. During an interview on 12/31/24 at 2:10 p.m., CNA 2 indicated she had previously transferred Resident B with another staff member due to her being a two person transfer. The resident currently required a mechanical lift for transfer due to her fractured ankle. CNA 2 reviewed the CNA assignment sheets for resident care needs as well as the Task tab on the electronic health record. She had noticed the resident was not getting out of bed as much as before her injury, but did not appear to be upset or in pain. During an interview on 12/31/24 at 2:10 p.m., CNA 6 indicated she had assisted Resident B frequently and had not noticed any major change in her since fracturing her ankle. The resident had gotten up from bed, maybe not as often, but close to her baseline. The resident had complained to her about discomfort in her ankle. CNA 6 indicated the resident had been a two person transfer prior to her injury because of her right side, specifically her right leg, not moving during transfer and the need for support. She received resident care needs from the CNA Assignment Sheets and from the Task information in the electronic health record. This citation relates to complaint IN00448842. 3.1-45(a)