STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Syracuse Skilled Nursing Facility, The	500 E Pickwick Dr Syracuse, IN 46567

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess a resident timely for 1 of 3 residents reviewed. This deficient practice resulted in a delay of treatment regarding sending the resident to hospital. The resident required acute medical care and remained in hospital for twenty days. (Resident 31) Finding includes:During an interview on 5/17/2026 at 11:07 A.M., Resident 31 indicated he had been recently hospitalized for sepsis, but could not recall the events that lead to him being sent to the hospital. Resident 31 indicated he woke up in the local Emergency Department and stayed in the hospital for over two weeks. Resident 31's record review was completed on 5/19/2026 at 10:00 A.M. Diagnoses included, but were not limited to: urinary tract infection, benign prostatic hyperplasia, obstructive and reflux uropathy, stage four chronic kidney disease, type two diabetes mellitus, peripheral vascular disease and congestive heart failure. A Quarterly Minimum Data assessment dated [DATE] indicated Resident 31 had not rejected care, had not had any behaviors and had intact cognition. Resident 31 had an indwelling urinary catheter and had been dependent for toileting, personal hygiene, showering and all mobility/transfer needs from the facility's staff.A Microbiology Specimen Summary dated 3/5/2026, indicated Resident 31 had a urinary tract infection. A Physicians' order dated 1/14/2026, indicated Resident 31 had an indwelling catheter and catheter care should be completed every shift.A Physician's order dated 3/5/2026, indicated Resident 31 was to be administered 500 milligrams (mg) of cephalexin (antibiotic) by mouth three times a day. A Care Plan, initiated on 3/5/2026 indicated Resident 31 had received antibiotics related to a urinary tract infection. Interventions to the Care Plan included, but were not limited to: administering medications per order, monitoring labs and cultures and report abnormal findings. A review of Resident 31's March Medication Administration Record indicated Resident 31 had not been administered his morning and mid-day dose of cephalexin on 3/7/2026, and lacked the documentation to indicate why the resident had not been administered the two doses of cephalexin. A review of the facility's Antibiotic Log indicated on 3/8/2026 the final results from the culture and sensitivity test of Resident 31's urine analysis had indicted the infection was from an organism called citrobacter previndii, and the antibiotic had been updated to sulfamethoxazole-trimethoprim. A Physician's order dated 3/8/2026, indicated Resident 31 was to be administered a 800-160 mg sulfamethoxazole-trimethoprim (antibiotic) tablet twice a day. A Nursing Progress Note dated 3/12/2026 at 6:00 P.M., and signed by the facility's Assistant Director of Nursing (ADON) indicated the Social Services Director had called the ADON at home to tell the ADON a psychologist had visited Resident 31 and found his mentation to be off. The psychologist notified the nurse responsible for Resident 31, but also reported the resident's change of condition to the SSD. The note indicated, Writer contacted the facility and spoke with the LPN on duty regarding the report. The LPN stated that the resident had been assessed and alteration from the resident's cognitive baseline was identified. The LPN was instructed to continue to monitor the resident for an changes in cognitive status or condition and to notify the provider and/or send the resident for further evaluation if a change from baseline is observed.Resident 31's record lacked the documentation that any assessment had been completed after Resident 31's psychologist reported the change in the resident's cognition. A Nursing Progress Note dated (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3/13/2026 at 7:45 A.M. indicated Resident 31 had been sent to a local ED for evaluation.A Change of Condition assessment dated [DATE] at 7:30 A.M. indicated Resident 31 was nonresponsive, had a blood glucose of 65 (70-149 is normal), had a blood pressure of 85/43 (normal 90-119/60-90) and respirations of 12 per minute (normal 12-20 per minute). The nurse contacted Emergency Services (911), and the resident was sent to the local ED. A review of the ED note dated 3/13/2026 indicated Resident 31 arrived by ambulance with a blood pressure of 85/47, a rectal temperature of 94.6 F (normal range 97.9 F- 100.4 F) and had been admitted to the Intensive Care Unit (ICU) for sepsis. A review of Resident 31's hospital discharge records indicated the resident was in the hospital from 3/13-4/2/2026.An interview with the Director of Nursing (DON) was completed on 5/19/2026 at 2:21 P.M. The DON indicated that on 3/12/2026 she had been the ADON and the person who had written the Nursing Progress Note on 3/12/2026 at 6:00 P.M. The DON indicated on 3/13/2026, the SSD had called her and reported that Resident 31's psychologist believed Resident 31's cognition had been off from the Resident's normal cognitive baseline. The DON called the facility, and because it had been shift change, the DON spoke to both the first shift nurse (6:00 A.M.- 6:30 P.M) and the second shift nurse (6:00 P.M. - 6:30 A.M.). The DON indicated the first shift nurse had reported that she had assessed Resident 31 and there was no change of condition. The DON indicated she had told both nurses to continue to monitor Resident 31 and send him to the local Emergency Department (ED) if his cognition was off from his baseline. The DON indicated Resident 31 should have had a head-to-toe assessment, including a cognitive check and vital signs (blood pressure, blood oxygen saturation level, pulse, temperature and respirations per minute). The DON indicated Resident 31's record lacked any documentation to indicated Resident 31 had had an assessment or any vital signs taken after the psychologist had reported Resident 31's change of condition to the nurse. During an interview on 5/20/2026 at 2:30 P.M., LPN 6 indicated she had been responsible for Resident 31 on 3/12/2026. LPN 6indicated she had been notified by the psychologist that Resident 31 seemed confused. LPN 6 indicated she assessed Resident 31 and found nothing to be off about his mentation. LPN 6 indicated when assessing Resident 31, the assessment included LPN 6 listening to the resident's lungs and asking the resident if was ok. LPN 6 indicated Resident 31 had told her he was fine and he was tired. LPN 6 indicated she did not ask him any other questions. LPN 6 believed she had taken a set of vitals and indicated if she had taken Resident 31's vitals, the vitals would be charted in Resident 31's medical record. During an interview on 5/21/2026 at 10:00 A.M., LPN 7indicated nurses work twelve-hour shifts and she worked from 6:00 P.M. on 3/12/2026 until 6:30 A.M. on 3/13/2026. LPN 7 denied speaking to the ADON about any concerns related to Resident 31. LPN 7 indicated the LPN 6 had given her report on Resident 31 at shift change and had not included any concerns. LPN 6 indicated she was familiar with the resident and she had not assessed Resident 31's cognition on 3/13/2026. LPN 7 indicated she woke Resident 31 up to give him his bedtime medication and that was the only time she had talked to the resident during her shift. If LPN 7 had known of any concerns related to Resident 31, she would have done a full assessment, including an assessment of the resident's cognition and a set of vital signs. LPN 7 indicated she had not seen the Nursing Note added by the facility's ADON on 3/12/2026 at 6:00 P.M during her shift. During an interview on 5/21/2026 at 11:00 A.M., RN 5 indicated she had been the nurse responsible for Resident 31 when he had been sent to the ED on 3/13/2026. RN 5 indicated she had not been made aware of any concerns related to Resident 31 by the previous shifts' nurse. RN 5 indicated Resident 31 had a dialysis appointment the morning of 3/13/2026 and she had been unable to wake the resident up. RN 5 indicated she had gotten a set of vitals and because Resident 31's blood pressure was low, had a low blood glucose of 65, had not responded to verbal stimuli and had respirations of twelve, she had called 911 and requested the resident be sent out to the local ED for evaluation. On 5/21/2026 at 10:00 A.M., the DON provided an undated policy titled, Guidelines for Assessments, and identified it as the policy currently used by the facility. The policy indicated, .Nurses and other qualified health professionals will perform appropriate assessments of the resident as indicated based on the routine schedule as (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	well as when a change in condition or circumstances and/or an event takes place that requires assessment by a qualified medical professional On 5/21/2026 at 11:00 A.M., the DON provided an undated policy titled, Change in Resident's Condition or Status, and identified it as the policy currently used by the facility. The policy indicated, .The nurse will notify the resident's attending physician when: . There is a significant change in the residents' physical, mental or psychological status . 6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status 410 Indiana Administrative Code 16.2-3.1-37

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure food was handled properly to prevent foodborne illness for 18 of 38 residents who consumed food being served at mealtime. Findings include:During a dining observation on 5/17/2026 between 11:48 A.M-12:02 P.M., Employees 4, 11, and 16 served a total of 14 cups and/or glasses of beverages and 6 plates of food touching the eating and drinking surfaces of the cups, glasses and plates. In addition, Employee 4's fingers were noted to be touching pudding and masked potatoes while she served food. During an interview with Administrator on 5/21/2026 at 11:05 A.M. he acknowledged that putting employee hands on the eating surface of plates of food was note a a proper way to serve food. During an interview with the Administrator, on 5/21/2026 at 11:10 A.M., a policy was requested from the administrator regarding proper food service techniques, but one was not provided prior the end of the survey. 3.1-21(i)(1) and (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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make a reasonable accommodation for a resident who required a grab bar on his bed for self-transfers for 1 of 8 resident's reviewed. (Resident 32) Finding includes:During an interview on 5/18/2026 at 8:56 A.M. Resident 32 indicated he was unable to get out of bed to use the bathroom by himself because he did not have an enabler bar on his bed. Resident 32 indicated he had been told on two different occasions, by the Maintenance Director (MD), that an enabler bar for the bed had been ordered, but the enabler bar had not yet been installed on his bed. During an interview with the MD on 5/19/2026 at 9:48 A.M., he indicated he had spoken to Resident 32 twice about the enabler bar after the facility had put in an order for the resident to have an enabler bar installed on the Resident 32's bed. The MD indicated Resident 32 was able get out of bed by himself, without the bar, but getting out of bed had caused the resident more pain in his right shoulder. The MD indicated Resident 32 had an older style bed and the enabler bars the facility had did not attach to the resident's bed correctly so the facility had ordered a new bed for Resident 32. After the invoice for the new bed was requested, the MD indicated the newer beds had previously been ordered and had already arrived at the facility before Resident 32 had even been admitted to the facility. The MD indicated he had been waiting for another resident with a newer bed to be discharged , in order to give Resident 32 a bed with an enabler bar. Resident 32's record was completed on 5/19/2026 at 2:00 P.M. Diagnoses included, but were not limited to: chronic diastolic congestive heart failure, depression, Parkinson's disease, epilepsy, osteoarthritis and chronic kidney disease. An admission Minimum Data Set (MDS) assessment dated [DATE], indicated Resident 32 had intact cognition and required moderate assistance for all transfers. A current Care Plan, initiated on 4/15/2026, indicated Resident 32 had been at increased risk for pain and discomfort related to Parkinson's disease, decreased strength and mobility and osteoarthritis. Current interventions included, but were not limited to: encourage me to sit, stand or lie a comfortable position, encourage frequent positioning changes to prevent strain on muscles and joints and administer analgesic (pain) medication as ordered per the Plan of Care.A Side Rail (enabler bar) assessment dated [DATE], indicated Resident 32 was safely able to use an enabler bar and had been educated on the risks and benefits of an enabler bar, and had given his consent for the use of an enabler bar. A current Physician's order dated 4/29/2026, indicated Resident 32 was to have had an enabler bar attached to his bed. On 5/20/2026 at 2:30 P.M., the Executive Director provided an undated policy titled, Guidelines to Provide Reasonable Accommodations of Needs, and identified the policy as the one currently used by the facility. The policy indicated, .It is the intent of this facility to provide, at minimum, reasonable accommodations as dictated by CMS, for those persons (residents) residing in the nursing home facility. The resident has the RESIDENT RIGHT to receive care and services with reasonable accommodation of needs and preferences except when the health or safety of the resident could be jeopardized . 3. The following are examples of areas of focus . Assistive devices for turning in bed or walking or moving up in bed (such atrapeze if ordered and recommended by therapy), visual or hearing enhancers or any equipment or device recommended by therapy or the physician will be obtained as indicated according to their individualized circumstances andassessment and also per their orders and care plan 410 Indiana Administrative Code 16.2-3.1-3(v)(1)

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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 record review and interview, the facility failed to ensure the physician was notified of elevated blood glucose levels timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 36) 1. A Record review for Resident 36 was completed, on 5/19/2026 at 10:11 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, peripheral vascular disease, neuropathy and intellectual disabilities.A Quarterly Minimum Data Set (MDS) assessment, dated, 4/20/2026, indicated Resident 36 was cognitively intact and received insulin injection for 7 days of the look back period.A Physician's Order, dated 1/20/2026, indicated Insulin Aspart Subcutaneous Solution Pen-injector 100 units/milliliter, inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units and call doctor; 401 - 450 = 12 units, subcutaneously four times a day for diabetes mellitus.The following blood sugars were recorded without notification to the physician:4/11/2026 at 4:57 P.M. 404 mg/dL (milligrams per deciliter)3/19/2026 at 10:32 P.M. 436 mg/dL3/18/2026 at 12:06 P.M. 406 mg/dL3/17/2026 at 8:51 P.M. 416 mg/dL3/14/2026 at 4:52 P.M. 404 mg/dL3/11/2026 at 9:45 P.M. 441 mg/dL3/1/2026 at 6:04 P.M. 402 mg/dL2/28/2026 at 4:41 P.M. 411 mg/dL2/23/2026 at 11:16 A.M. 435 mg/dL2/20/2026 at 9:41 P.M. 462 mg/dL2/20/2026 at 5:35 P.M. 421 mg/dL2/19/2026 at 4:52 P.M. 496 mg/dL2/18/2026 at 11:48 A.M. 407 mg/dL2/15/2026 at 12:24 P.M. 426 mg/dL2/9/2026 at 11:34 A.M. 425 mg/dL2/7/2026 at 9:39 P.M. 448 mg/dL A Care Plan, dated 11/26/2025, indicated Resident 36 was at risk for unstable blood sugars related to diabetes and required insulin. Interventions included, but were not limited to: administer insulin as ordered, document all insulin administrations and blood glucose readings and report any abnormal blood glucose readings or insulin results promptly to the provider.During an interview, on 5/21/2026 at 11:49 A.M., the Director of Nursing (DON) indicated when the resident had exhibited a blood sugar over 400 mg/dL, the provider/physician should have been notified.A Policy was provided, on 5/21/2026 at 1:22 P.M., by the Executive Director. The policy titled, Changes in Resident's Condition or Status, indicated, .It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status.1. Th nurse will notify the resident's attending physician when: There is a need to alter the resident's treatment plan significantly. 410 IAC (Indiana Administrative Code) 3.1-5(a)(3)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure a gradual dose reductions for psychotropic medications was attempted for 1 of 5 residents reviewed for unnecessary medications. (Residents 24) Findings include: 1. A record review for Resident 24 was completed on 5/19/2026 at 9:55 A.M. Diagnoses included, but were not limited to: anxiety, depressive disorder, and altered mental status. A physician's order initiated on 10/30/2025 for Lorazepam 0.5 mg, give 0.25 mg by mouth two times a day for anxiety. The order had been discontinued on 4/16/2026. A physician's order, dated 4/16/2026 indicated Lorazepam 0.5 mg, give 0.25 mg by mouth two times a day for anxiety had been reordered. A physician's order ,dated 10/07/2025 indicated behavior monitoring every shift for tearful periods, isolation, anxiety, depression. Observe for any new onset and/or worsening side effects with psychotropic drugs common side effects every shift. A review of behavior monitoring reports indicated the resident had exhibited no behaviors from December 14, 2025 through May 20, 2026. A pharmacy review of medications document, dated 12/14/2025, recommended reducing the Lorazepam from 0.25 mg twice daily to 0.25 mg daily. There was no provider's signature and date acknowledging receipt of the informaiton on the letter of recommendation. A pharmacy review of medication document, dated 2/20/2026, recommended reducing the Lorazepam dose from 0.25 mg twice daily to 0.25 mg daily. The FNP had agreed with recommendation on 2/20/2026 but the order had not been initiated in Resident 24's record. During an interview with the DON, on 5/22/2026 at 11:32 A.M. she indicated the change order should have been entered by the DON. A policy for following a physician's order was requested but none was provided prior the the survey's exit. 16.2 Indiana Administrative Code (IAC) 3.1-3(w)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to ensure 11 of 15 nursing staff (Director of Nursing, RN 5, LPNs 6, 7, 9, 10, 12 and 14, QMAs 8, 13 an 15) demonstrated competency related to following medication orders for 1 of 6 residents reviewed. (Resident 31)Finding includes: Resident 31's record review was completed on 5/19/2026 at 10:00 A.M. Diagnoses included, but were not limited to: urinary tract infection, benign prostatic hyperplasia, obstructive and reflux uropathy, stage four chronic kidney disease, type two diabetes mellitus, hyperthyroidism, major depressive disorder, anxiety disorder, peripheral vascular disease, hypertension and congestive heart failure. A Quarterly Minimum Data assessment, dated 2/26/2026, indicated Resident 31 had not rejected care, had not had exhibited any behaviors and had intact cognition. A review of Resident 31's February 2026 Medication Administration Record indicated Resident 31 had the following orders:- Give one 25 milligrams (mg) capsule of metoprolol succinate (anti-hypertensive) by mouth one time a day every Tuesday, Thursday, Saturday and Sunday. Hold if SPB <110 or DBP <80- Give 100 mg capsule of bupropion HCl (treats depression and anxiety) once a day- Give 50 micrograms (MCG) of cholecalciferol (Vitamin D) once a day- Give 75 mcg of levothyroxine sodium (treats hyperthyroidism) once a day Resident 31's February 2026 MAR indicated the resident was administered metoprolol without having had his blood pressure assessed prior to administration on the following dates: 2/1, 2/5, 2/7, 2/8, 2/10, 2/12, 2/14, 2/15, 2/17, 2/19, 2/21, 2/22, 2/24, 2/26 or 2/28/2026. The nursing staff administering the medications on those dates included RN 5, LPN 6, QMA 8, LPN 9 and LPN 10. In addition, Resident 31 was not administered bupropion, cholecalciferol or levothyroxine, as ordered, on the morning of 2/14/2026. The resident's record lacked any documentation indicating why the resident had not been administered the prescribed medications. A review of Resident 31's March 2026 Medication Administration Record indicated Resident 31 had the following orders:- Give one 25 mg capsule of metoprolol succinate by mouth one time a day every Tuesday, Thursday, Saturday and Sunday. Hold if SPB <110 or DBP <80- Give one 40 mg capsule of atorvastatin Calcium (treats hyperlipidemia) once daily-Give one 0.4 mg capsule of tamsulosin HCl (treats prostate) once daily-Give one 0.5 mg tablet of alprazolam (treats anxiety) twice a day-Give 5 mg of apixaban (blood thinner) twice a day-Give one 40 mg tablet of furosemide (water pill) twice a day-Give one 500 mg tablet of cephalexin (antibiotic) three times a day Resident 31's March 2026 MAR indicated the resident had been administered metoprolol without having had his blood pressure assessed prior to the administration of the medication on the following dates: 3/1, 3/5, 3/8, 3/10 and 3/12/2026. Nursing staff administering medication on those dates included QMA 8, LPN 6, LPN 9 and LPN 10. In addition, Resident 31 was not administered alprazolam, furosemide, cephalexin and apixaban on 3/7/2026. The clinical lacked the documentation indicating why the resident had not been administered the prescribed medications.A review of Resident 31's April 2026 Medication Administration Record indicated Resident 31 had the following orders:- Give one 25 mg capsule of metoprolol succinate by mouth one time a day every Tuesday, Thursday, Saturday and Sunday. Hold if SPB <110 or DBP <80 Resident 31's April 2026 MAR indicated the resident had been administered metoprolol without having had his blood pressure assessed prior to the administration of the medication on the following dates: 4/16, 4/18, 4/21, 4/25, 4/26 and 4/30/2026. The nursing staff involved included LPN 12, QMA 12 and LPN 14 In addition, Resident 31 was administered metoprolol with blood pressures assessed that indicated his medication should have been held on the following dates: 4/4, 4/5, 4/9, 4/11 and 4/12/2026. The nursing staff involved included the Director of Nursing, RN 5, QMA 8 and LPN 9. A review of Resident 31's May 2026 MAR indicated Resident 31 had the following order:- Give one 25 mg capsule of metoprolol succinate (anti-hypertensive) capsule by mouth one time a day every Tuesday, Thursday, Saturday and Sunday. Hold if SPB <110 or DBP <80Resident 31's May 2026 MAR indicated Resident 31 had been administered metoprolol without (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	having had his blood pressure assessed on the following dates: 5/2, 5/3, 5/7, 5/9, 5/10, 5/12, 5/14, 5/15 and 5/19/2026. Nursing staff involved included LPN 7, LPN 12, QMA 13, LPN 14 and QMA 15. During an interview on 5/21/2026 at 10:00 A.M., LPN 7 indicated Resident 31 should not have been administered metoprolol if there had not been a blood pressure assessed and recorded for the resident at the time of the medication administration.During an interview on 5/21/2026 at 11:30 A.M., RN 5 indicated she should not have administered metoprolol in February, March or April 2026 if there had not been a blood pressure assessed at the time of the medication administration, or if the blood pressure results were out of range per the Physician's order.During an interview on 5/21/2026 at 11:45 A.M., the DON indicated Physician orders should be followed as written, and any time metoprolol was given without the staff taking a blood pressure, the staff had been incorrect regarding medication administration. The DON indicated if a medication was not given, there should have been documentation in the chart indicating why a medication had not been given per the Physician order. The DON indicated medication administration was part of the new hire orientation processes and all staff who passed medications had to have their medication administration skills checked and signed off by their trainer. A medication administration skill check included following parameters a medication may have when administering medications to residents. A review of the skills check off for medication administration was reviewed for the DON, RN5, LPN 6, LPN 7, QMA 8, LPN 9, LPN 10, LPN 12, QMA 13, LPN 14 and QMA 15. All of the included nursing employees had had their medication administration skill completed without any concerns before the staff member had administered medications without supervision. A policy for following the Physician's order was requested on 5/20/2026 at 2:30 P.M., but one was not provided prior to the exit of the survey on 5/21/2026 at 2:00 P.M. 410 Indiana Administrative Code 16.2-3.1-14(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Syracuse Skilled Nursing Facility, The	500 E Pickwick Dr Syracuse, IN 46567

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to follow physician ordered medication monitoring based on physician orders for 1 of 5 residents reviewed for unnecessary medications. (Residents 6) Findings include:1. A record review for Resident 6 was completed on 5/18/2026 at 1:00 P.M. Diagnoses included, but were not limited to: acute on chronic diastolic congestive heart failure and hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 3/23/2026, indicated Resident 6 was cognitively intact and received a diuretic.A Physician's Order, dated 4/10/2026, indicated a weekly weight was to be obtained for congestive heart failure and the physician was to be notified of a weekly weight gain of two pounds or more.A review of Resident 6's weights for April 2026 and May 2026, indicated a weight had only been obtained for the weeks including the dates of 4/29/2026, 5/11/2026 and 5/13/2026.During an interview, 5/21/2026 at 10:32 A.M., the Director of Nursing (DON) indicated Resident 6's weight values should have been documented weekly in the medical record. She indicated an electronic prompt to document the weight had not been added to the physician order in the electronic clinical record.A Policy was provided, on 5/21/2026 at 1:22 P.M., by the Executive Director. The policy titled, Changes in Resident's Condition or Status, indicated, .It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status.1. Th nurse will notify the resident's attending physician when: There is a need to alter the resident's treatment plan significantly. 410 IAC (Indiana Administrative Code) 3.1-48(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Syracuse Skilled Nursing Facility, The	500 E Pickwick Dr Syracuse, IN 46567

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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 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 document review, the facility failed to ensure time sensitive medications were dated when opened for 1 of 38 residents (R 25) on 1 of 3 nursing units. (Teal unit) Findings include:During an inspection of the medication cart on the Teal Unit on 5/20/2026 at 9:45 A.M., a bottle of eye drops, for Resident 25, opened had been opened, but did not have an open date on the bottle.During an interview with QMA 3, on 5/20/2026 at 9:52 A.M. she indicated the eye drops should have been dated when they were opened.A policy titled, Medication Storage in the Facility, provided by the administrator on 5/21/2026 at 1:22 P.M. and indicated the policy was the one currently used by the facility. The policy indicated.Outdated drugs will be immediately withdrawn from stock by the facility.A policy for dating medications when opened was requested but one was not provided.16.2 Indiana Administrative Code (IAC) 3.1-25(k)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. Building B. Wing	05/21/2026

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Waters of Syracuse Skilled Nursing Facility, The	500 E Pickwick Dr Syracuse, IN 46567

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on interview, observation and record review, the facility failed to maintain an effective pest control program related to flies in a resident's room for 1 of 38 residents reviewed. (Resident 25)Finding includes:During an interview on 5/18/2026 at 10:38 A.M., Resident 25 indicated she had had a fly problem for about a year. Resident 25 indicated staff had been aware of the flies and the facility had had a local pest control company treat her room for drain flies. During an observation on 5/18/2026 at 10:40 A.M., a dozen flies could be seen on the walls of Resident 25's room, and six flies could be seen on the resident's bathroom walls. During a tour of the environment with the Maintenance Director (MD) and Housekeeping Supervisor (HS) on 5/19/2026 at 9:35 A.M., both the MD and HS denied knowledge of any reported issue in Resident 25's room and/or bathroom involving flies. During an interview with Resident 25's family member on 5/19/2026 at 9:38 A.M., the family member indicated Resident 25 had been dealing with drain flies for about a year. She indicated she had bought the resident E-Z traps (fly trap with all four sides of the trap covered in sticky adhesive) to take care of the problem eight or nine months prior. The family member went into Resident 25's bathroom and removed the E-Z trap from behind the toilet and showed the MD and HS. The E-Z trap had four sides and was eighty percent covered in dead flies. During an interview with the MD and the HS on 5/19/2026 at 9:39 A.M., both the MD and HS indicated they were unaware Resident 25 had a drain fly problem and denied knowing there was an E-Z insect trap located behind Resident 25's toilet. The HS indicated housekeeping mopped the bathroom floors of the resident's rooms daily and should have noticed the E-Z trap. The MD indicated he toured the building daily and completed rounds on a handful of rooms once a month to identify possible areas of concern. The MD indicated he had been in Resident 25's room within the last six months and denied knowing there had ever been an issue with flies. A review of the pest control invoices, completed on 5/20/2026 at 9:00 A.M., indicated Resident 25's room had been inspected and treated on 6/25/2025 and 8/25/2025 for insect activity. On 5/21/2026 at 1:30 P.M., the Executive Director provided an undated policy titled, Guidelines for Pest Control, and identified it as the policy currently used by the facility. The policy indicated, It is the policy of the facility to ensure that an effective Pest Control Program is in place. An effective pest control program is defined as-measures to eradicate and contain common household pests. These include but are not necessarily limited to roaches, ants, mosquitoes, flies, gnats, maggots, bees, wasps, hornets, mice, rats, spiders, snake(s), ticks, termites, other . 2. The maintenance staff and all other staff will be cognizant of the necessity to maintain a clean, safe, and comfortable, homelike environment that is free of pests or rodents. 3. Upon a sighting of any pest or rodent or any evidence of a pest or rodent by any person In the facility, the Administrator will be notified. The problem will be addressed to include contacting the Pest Control vendor should an off-schedule visit be necessary 410 Indiana Administrative Code 16.2-3.1-19(f)(3)