STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wakarusa Skilled Nursing Facility, The	300 N Washington St Wakarusa, IN 46573

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure showers were provided to 1 of 2 residents requiring assistance from facility staff. (Resident F).Findings include:In a confidential interview on 3/12/26, the interviewee alleged Resident F had not received showers per his preference and care plan. He was to receive 2 showers per week with moderate assistance from staff.On 3/16/26 at 11:09 A.M., Resident F's record was reviewed. Diagnoses included a history of strokes.A quarterly Minimum Data Set (MDS) assessment, dated 1/26/26, indicated Resident F was cognitively intact, had no behaviors or rejection of care, and required moderate assistance from staff for transferring in/out of the shower and moderate assistance with bathing.Care plans, revised on 2/9/26, indicated Resident F required assistance with activities of daily living (ADL) to maintain his current level of functioning. Staff were to provide assistance with all ADL's as required by his dependent needs such as transferring and bathing. The care plans indicated he had specific daily preferences important to him, including choosing a shower or bath.A master shower schedule indicated the resident was to receive a shower, 2 times per week, on Wednesday and Saturday in the evening.A Documentation Survey Report, dated February 2026, indicated Resident F received a shower on 2/18/26 and 2/25/26. He was given a complete bed bath on 2/19/26. Scheduled showers were not provided on 2/4, 2/7, 2/11, 2/14, 2/21, or 2/28/26.A Documentation Survey Report, dated March 2026, indicated Resident F was given showers on 3/5 (Thursday) and 3/11/26. Scheduled showers were not provided on 3/7/26 or 3/14/26.On 3/16/26 at 2:50 P.M., the Director of Nursing (DON) was interviewed. She indicated Resident F was scheduled to receive 2 showers per week, on Wednesday and Saturday evenings. According to Documentation Survey Reports for February and March 2026, the resident had not received his showers as scheduled, 2 times per week. The DON indicated it was the facility policy to provide care according to resident's preference of shower or bath, at least 2 times per week, on assigned days. She indicated there was a shower schedule available at each nurse's station. The shower schedule indicated assigned showers for certain days and shifts, for each resident and were to be followed.This Citation relates to Intake 2798019.410 IAC 16.2-3.1-38(3)(b)(2)

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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure timely assessments following a change in condition were completed for 1 of 3 residents reviewed (Resident D). Findings include:A report by Adult Protective Services, alleged Resident D had become ill on 2/20/26 but had been sent to dialysis as scheduled. At the dialysis center, the nurse stopped Resident D's dialysis treatment early and called the facility to come pick her up. The dialysis center nurse, allegedly spoke with a nurse at the facility and indicated the resident needed to be seen by the doctor or nurse practitioner (NP) to rule out an infection (sepsis). The resident was sent to the hospital on 2/22/26 where she had emergency surgery for a necrotic (dead) bowel and sepsis.On 3/12/26 at 11:36 A.M., Resident D's record was reviewed. Diagnoses included end-stage renal disease with dependence on dialysis and dementia.A quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated Resident D could usually make herself understood and usually understood others. She had severely impaired cognition and no behavior symptoms affecting her care. She required moderate to maximum assistance with her activities of daily living. She denied having acute or chronic pain. The resident was prescribed anti-coagulant medication taken daily to thin her blood.Current care plans, dated 8/7/2025, indicated Resident D had kidney disease requiring dialysis. Staff were to ensure she got to her dialysis appointments 3 times per week, on Monday, Wednesday, and Friday from 8:00 a.m.-noon. The resident could be resistant to care related to swallowing medications and removing the pressure dressing on her dialysis access port. She had the potential for pain and staff were to observe for signs/symptoms of pain, provide medications for pain as ordered, and notify the doctor of uncontrolled pain.A dialysis communication form, dated 2/20/26 at unknown time, indicated assessment of post-dialysis treatment was completed by the dialysis center Registered Nurse (RN) 2. The assessment indicated Resident D required extra fluids during her treatment to keep her systolic (top number) blood pressure >100. RN 2 indicated the resident needed to be seen by the nurse or doctor to rule out sepsis.Progress notes, on 2/20/26, did not indicate the resident had returned from dialysis early. She had not been assessed for signs of sepsis and the doctor had not been notified of the dialysis center's concern for sepsis.A Medication Administration Record (MAR), dated 2/20/26 at 6:40 p.m., indicated Resident D had been given extra strength Tylenol-2 tablets by mouth for complaints of abdominal pain, not responsive to repositioning. A change in condition form (SBAR), dated 2/20/26 at 6:45 p.m., indicated the NP was notified Resident D was complaining of abdominal pain and tenderness. An order was given to obtain a STAT abdominal x-ray. If symptoms persisted, the resident was to be sent to the hospital. A progress note, dated 2/20/26 at 7:23 p.m., indicated Resident D was repeatedly calling out, complaining of abdominal pain, and stating she could hardly breathe. Her respirations were unlabored and even. She had been given Tylenol at 6:40 p.m. but continued to complain of pain. Her abdomen was rounded and soft to touch. The resident complained of tenderness in her right upper abdomen. Her bowel sounds were normal and she'd had a bowel movement that morning. The resident's family was notified of the resident's pain and they indicated the resident had a history of liver and bowel conditions. The family member was agreeable to transfer the resident to the hospital if necessary.A progress note dated 2/20/26 at 10:36 p.m., indicated the NP was notified of the residents abdominal x-ray results completed at 8:10 p.m. The abdominal x-ray showed no acute abdominal issues such as obstruction. Resident D was last observed at 9:35 p.m. and had been sleeping but easily arousable. She had no yelling out, moaning, or facial grimacing to indicate continued pain. The NP gave orders to monitor the resident closely and send to the hospital if she developed fever or worsening pain.A follow-up condition change progress note dated 2/21/26 at 2:31 a.m., indicated Resident D had been resting in bed with no complaints of stomach pain. There were no further assessments completed or progress notes written after 2/21/26 at 2:31 a.m. until 2/22/26 at 7:42 a.m.A change in condition (SBAR) form, dated 2/22/26 at 7:42 a.m., indicated Resident D had severe abdominal pain. The resident was yelling out with increased pain in her lower (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abdomen and severe pain in her right lower abdomen. Orders were given to send the resident to the hospital for evaluation and treatment.On 3/12/26 at 2:30 P.M., Licensed Practical Nurse (LPN) 4 was interviewed. She indicated she had worked the evening shift on 2/20/26 and observed Resident D in severe abdominal pain. She had not been told in report from 1st shift, the resident's dialysis treatment had been stopped early due to her not feeling well. LPN 4 checked on the resident around 6:00 p.m. after she had refused supper and was complaining of abdominal pain. LPN 4 tried re-positioning her in bed without relief. She assessed the resident, administered Tylenol per orders and notified the NP of the resident's condition. She observed the resident appearing to sleep around 9:30 p.m. and had called the NP to report results of the STAT abdominal x-ray. When asked, LPN 4 indicated she had not seen the communication form from dialysis as the resident attended treatments on the day shift. Upon return to the facility from dialysis, day shift nurses would check the resident's vital signs and pressure bandage, review dialysis communication forms found in the dialysis book which went with the resident to/from dialysis, and follow the forms instructions.On 3/16/26 at 9:27 A.M., RN 2 was interviewed. He indicated on 2/20/26, during Resident D's dialysis treatment, her blood pressure dropped more than usual. She was given extra fluids to keep her systolic blood pressure up to a safe level. He indicated the resident had been more restless than usual, was agitated and wanted to leave. RN 2 indicated concern the resident was developing sepsis due to her unusual blood pressure drop. He called the facility and spoke with the unit manager-LPN 6. He reported to LPN 6, Resident D was more restless and agitated than usual, had wanted to stop dialysis early, had low blood pressure, concerns for developing sepsis, and need for nurse or doctor assessment of her condition.On 3/16/26 at 12:38 P.M., the Director of Nursing (DON) was interviewed. She indicated LPN 6 should have reviewed the dialysis form, performed an assessment of the resident's condition upon return, and notified the NP or doctor of dialysis staff concerns. The DON indicated residents assessed as having an acute change in condition, were to be assessed for 72 hours following to ensure the acute change had not worsened or had resolved. On 3/16/26 at 1:30 P.M., the Administrator and Regional Nurse Consultant (RNC) were interviewed. The RNC indicated when an acute change in condition form (SBAR) was opened and completed, the form would trigger follow up assessments to be completed every shift for 72 hours. The Administrator indicated the follow up assessments triggered by the SBAR, would be found in the nurse progress notes. The Administrator nor RNC were able to locate follow up assessments in the resident's record but indicated the assessments should have been completed.On 3/16/26 at 3:28 P.M., LPN 8 indicated she had worked on Saturday, 2/21/26 during the day with Resident D. She indicated being told in report, the resident had stopped her dialysis treatment early on Friday 2/20/26 due to complaints of being sick and nauseous. Staff reported to her, the resident hadn't been eating well for the past few days due to decrease in appetite. LPN 8 indicated she had not performed an assessment on the resident because there had been no further reports of abdominal pain and the abdominal x-ray done the night before had been negative. There were no follow-up assessments completed following the change in condition (SBAR) started on 2/20/26 when Resident D complained of abdominal pain and refused 2 meals. The resident was sent to the hospital on 2/22/26 for severe abdominal pain.This Citation relates to Intake 2798019.410 IAC 16.2-3.1-37