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	03/14/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 51598 Based on interview and record review, the facility failed to ensure a resident's choice of Advance Directive was documented consistently in the medical record and staff were aware of the resident's choice for 1 of 1 residents reviewed for Advance Directives (Resident 31). Findings include: During a record review for Resident 31, completed on 3/11/25 at 9:22 A.M., the following conflicting information regarding the resident's advance directives/code status was noted: the face sheet indicated the resident was a Do Not Resuscitate (DNR). However, the physician's orders included orders indicating the resident was a DNR and a Full Code (initiate life sustaining measures, such as chest compressions if heart stops). A Indiana Physician Orders for Scope of Treatment (POST) form dated and signed on 2/20/2025 for Resident 31, indicated the resident wanted to be a full code. The current Care Plan for Resident 31, dated 3/4/2025, indicated a code status of DNR. During an interview, on 3/11/2025 at 1:11 P.M., LPN 8 indicated a resident's code status located on the face sheet and if it was not listed on the face sheet, facility staff were to look in the resident's physician's orders or documents. LPN 8 confirmed the code status for Resident 31 on the face sheet, physician orders, and POST were conflicting and did not match. During an interview, on 03/11/25 1:17 P.M., the DON indicated Resident 31 had recently changed her code status. The DON indicated the code status should have been updated and confirmed the clinical record did not match Resident 31's current code status. A current facility policy was provided by the Regional Nurse, on 3/13/2025 at 2:35 P.M. The policy titled, Advanced Directives Policy and Procedure indicated the facility provides residents the right to accept or refuse treatment and formulate advanced directives . 3.1-4 (f) (5)

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 - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51598 Based on observation, interview and record review the facility failed to follow a Physicians order to hold a hypotensive medication (Resident 24), failed to keep a complete hospice binder (Resident 55), failed to follow physician's orders regarding hypertensive medication (Resident 6), failed to provide recommended emollient for skin (Resident 39), and failed to provide sliding scale insulin for 2 day for a resident with diabetes mellitus (Resident 331). Finding includes: 1. The record for Resident 24 was reviewed on 3/12/2025 at 9:43 A.M. Diagnoses included but were not limited to: pulmonary hypertension, orthostatic hypotension, obesity, congestive heart failure, and anxiety. Physician Orders included but were not limited to: carvedilol 3.125 milligrams (mg) daily, torsemide 10 mg daily, and midodrine 5 mg three times a day, hold for systolic blood pressure (SBP) greater than 120. The Medication Administration Record MAR for January 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 42 times. The MAR for February 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 28 times. The MAR for March 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 7 times. During an interview on 3/12/2025 at 2:34 P.M., Regional Nurse indicated on the days with SBP greater than 120, the midodrine should not have been administered. During an interview on 3/13/2025 at 10:41 A.M., LPN 7 indicated if Resident 24's SBP was greater than 120 the facility staff should not have administered the medication. 49994 2. A record review was completed for Resident 55 on 3/13/2025 at 11:32 A.M. Diagnoses included, but were not limited to: senile degeneration of the brain and dementia. A Quarterly MDS (Minimum Data Set) assessment, dated 2/10/2025 indicated Resident 55's cognition was significantly impaired. A significant changed MDS was completed on 1/26/2025 indicating the resident was receiving hospice services. A Physician's Order, dated 1/15/2025 indicated hospice was to evaluate and treat the resident per family request. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 1/17/2025 indicated Resident 55 was accepted to (name of hospice) and was a DNR (do not resuscitate). A current Care Plan, revised on 1/20/2025 indicated Resident 55 elected hospice services and was to be followed by hospice care (name of hospice). Interventions included, but were not limited to: Staff nurses will contact hospice with information that affects resident care. On 3/13/2025 at 1:35 P.M., a review of Resident 55's hospice book was completed. The resident's hospice book lacked documentation of the resident's medications, physician's orders, a signed DNR and any communication between the facility and (name of hospice). During an interview on 3/13/2025 at 1:38 P.M., the DON indicated the resident's hospice book should have had a copy of the resident's signed DNR, current orders, medications and any communication between the facility and (name of hospice). On 3/13/2025 at 2:16 P.M., the DON provided a policy titled, Guidelines for Palliative Care- Hospice Care, dated 10/9/2024 and indicated it was the policy currently being used by the facility. The policy indicated, : What must a LTC facility do as their part for partnering with the hospice provider? D. A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the residents are addressed and met 24 hours per day 3. A record review was completed for Resident 6 on 3/11/2025 at 1:09 P.M. Diagnoses included, but were not limited to: atrial fibrillation, coronary atherosclerosis and hypertension. A Physician's Order indicated Resident 6 was to receive Triamterene and Hydrochlorothiazide 37.5-25 mg (milligram) tablet by mouth, one time a day for hypertension. The medication was to be held if the resident's systolic blood pressure was below 110 mmHg (millimeters per mercury). A review of Resident 6's MAR (medication administration record) indicated the Triamterene and Hydrochlorothiazide 37.5-25 mg tablet was documented as given on the following dates, when the resident's blood pressure was outside the recommended parameter: - on 11/21/2024 the resident's blood pressure was 100/50 mmHg. - on 11/22/2024 the resident's blood pressure was 102/54 mmHg. - on 12/11/2024 the resident's blood pressure was 97/53 mmHg. - on 12/22/2024 the resident's blood pressure was 108/62 mmHg. - on 1/4/2025 the resident's blood pressure was 102/60 mmHg. - on 1/21/2025 the resident's blood pressure was 88/58 mmHg. - on 2/1/2025 the resident's blood pressure was 91/52 mmHg. - on 2/16/2025 the resident's blood pressure was 105/58 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 1:53 P.M., the DON indicated the resident's medication should have been held on the days her blood pressure was outside the recommended parameters. On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, Guidelines for Physician Orders- Following Physician Orders, dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated, .4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received 45120 4. During an interview, on 3/10/2025 at 11:09 A.M., Resident 30 indicated she had very dry skin. A record review for Resident 30 was completed, on 3/13/2025 at 9:17 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and hemiplegia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/11/2025, indicated Resident 30 had moderate cognitive impairment and impaired range of motion to the upper and lower extremities on one side of her body. A Nurse Practitioner Skin and Wound Progress Note, dated 2/28/2025 at 9:26 A.M., indicated Resident 30's skin was dry, flaky and atrophied and was observed to have dry skin generalized to her entire body. An emollient skin application as needed for dry and/or atrophic skin was recommended by the nurse practitioner. However, there were no orders for an emollient to be provided to Resident 30 for her dry skin. A Care Plan, initiated 5/10/2025 and revised on 8/13/2024, indicated Resident 30 was at risk for additional areas of skin breakdown. The goal included, but was not limited to: Resident 30 would be provided with preventative measures to avoid skin breakdown. Interventions included, but were not limited to: monitor skin daily during care and notify the physician and family of any change in skin integrity. During an interview, on 3/14/2025 at 10:14 A.M., the Director of Nursing (DON), indicated Resident 30 should have had an order for an emollient if recommended by the nurse practitioner. During an interview, on 3/14/2025 at 11:19 A.M., the Regional Director of Clinical Services indicated the emollient for Resident 20 would have been ordered as needed if an issue of her skin arose. A policy was provided, on 3/14/2025 at 1:00 P.M., by the Director of Nursing. The policy titled, Guidelines for Preventative Skin Care, indicated, .Procedure: 1) Appropriate skin care is provided by staff each shift and/or as necessary 4. During an interview, on 3/10/2025 at 11:41 A.M., Resident 331 indicated the meals provided by the facility were high in carbohydrates and her blood sugars had been running high since her admission to the facility. (continued on next page)

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	155582	A. Building B. Wing	03/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review for Resident 331 was completed on 3/12/2025 at 10:03 A.M. Diagnoses included, but were not limited to: pathological fracture of left femur, malignant neoplasm of liver and lower lobe of left bronchus, secondary malignant neoplasm of bone and diabetes mellitus type 2. Resident 331 admitted to the facility on [DATE]. The Admission MDS assessment had not yet been completed and was still in progress. Hospital discharge instructions, dated 3/7/2025, indicated the following order: Insulin Lispro 100 units per milliliter Solution Sliding Scale subcutaneously as ordered as needed for serum glucose, see parameters: 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-400 give 9 units; Above 400 give 10 units. A Physician's Order, dated 3/7/2025 and discontinued 3/7/2025 by a pharmacy interchange order, indicated the following order was to be implemented for the interchange: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; (continued on next page)

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	155582	A. Building B. Wing	03/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	321-360 give 8 units; 361-400 give 9 units; Above 400 give 10 units. The Physician's Orders for Resident 331, from the pharmacy interchange order, was dated 3/10/2025 and indicated the following: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-399 give 9 units and notify MD if over 350; 400-500 give 10 units and notify MD. A review of the Medication administration record indicated Resident 331 received Lispro sliding scale insulin on the following dates between 3/7/2025 and 3/10/2025. -3/7/2025 at 4:30 P.M. -3/10/2025 at 7:30 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M. Resident 331 did not receive any sliding scale insulin on 3/8/2025 or on 3/9/2025. A Care Plan, initiated 3/10/2025, indicated Resident 331 had a diagnosis of diabetes mellitus type 2 with the risk of hypo/hyperglycemia. Interventions included, but were not limited to: administer medications and insulins per order. During an interview, on 3/14/2025 at 11:28 A.M., the Regional Director of Clinical Services indicated the pharmacy had issued a therapeutic interchange of the sliding scale insulin on 3/7/2025 and the sliding scale insulin order was not signed by the nursing department and implemented until 3/10/2025. She indicated Resident 331 had missed two days of the sliding scale insulin ordered. (continued on next page)

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	155582	A. Building B. Wing	03/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, Guidelines for Physician Orders- Following Physician Orders, dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated : . It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care . 4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received 3.1-37(a)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45120 Based on observation, record review and interview, the facility failed to provide non-invasive mechanical ventilation equipment for 1 of 3 residents and failed to properly store respiratory treatment for 1 of 3 residents reviewed for respiratory services. (Resident 333 & 16) Findings include: 1. During an observation on 3/10/2025 at 10:02 A.M., Bi-Pap (bi-level positive airway pressure) equipment was observed in Resident 333's room on a table by the door of her room. When Resident 333 was questioned about the Bi-Pap equipment, she indicated she had been admitted to the facility a week ago and was not sure why she had the Bi-Pap equipment in her room. During an observation, on 3/11/2025 at 9:26 A.M., 3/12/2025 at 9:32 A.M. and 3/13/2025 at 9:12 A.M., Bi-Pap equipment was observed on a table by Resident 333's door in a plastic bag. A record review for Resident 333 was completed on 3/12/2025 at 9:33 A.M. Diagnoses included, but were not limited to: acute respiratory failure with hypoxia, rib fracture, panic disorder and emphysema. The Admission Minimum Data Set (MDS) assessment .had not been completed yet. A Physician's Order for Resident 333, dated 3/5/2025, indicated to apply the Bi-Pap mask as ordered while sleeping and remove while awake for sleep apnea. The order indicated an inspiratory positive airway pressure setting of 10 cm H2O (centimeters of water) and expiratory positive airway pressure setting of 6 cm H2O. There was no baseline care plan related to Resident 333's diagnosis of obstructive sleep apnea or the use of the Bi-Pap machine. During an interview, on 3/13/2025 at 9:12 A.M., Resident 333 indicated she had not worn the Bi-Pap mask since before admission to the facility. She indicated the Bi-Pap mask had not been offered to her for use. During an interview, on 3/14/2025 at 10:12 A.M., the Director of Nursing (DON) indicated Resident 333 should have been wearing her Bi-Pap equipment, unless she had declined. The DON indicated any declination of wearing the Bi-Pap would have been documented. There was no documentation regarding any refusals to wear the Bi-Pap in Resident 333's record. 2. During an observation, on 3/10/2025 at 10:50 A.M., 3/12/2025 at 1:18 P.M., 3/13/2025 at 2:14 P.M. and 3/14/2025 at 9:34 P.M., Resident 16's C-Pap (continuous positive airway pressure) mask was stored uncovered in the top drawer of her bedside table. A record review for Resident 16 was completed on 3/12/2025 at 1:15 P.M. Diagnoses included, but were not limited to: Parkinson's disease, shortness of breath and obstructive sleep apnea. (continued on next page)

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	155582	A. Building B. Wing	03/14/2025

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Waters of Wakarusa Skilled Nursing Facility, The	300 N Washington St Wakarusa, IN 46573

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly MDS assessment, dated 2/25/2025, indicated Resident 16 was cognitively intact and used non-invasive mechanical ventilation (C-Pap). A Physician's Order, dated 8/16/2024, indicated Resident 16 to wear the C-Pap at bedtime and during naps for sleep apnea. A Care Plan initiated, on 5/13/2024, indicated Resident 16 was at risk for altered sleep/respiratory function related to obstructive sleep apnea. During an interview, on 3/14/2025 at 10:13 A.M., the DON indicated the C-Pap mask should have been stored in a dated respiratory bag when the mask was not in use. A policy was provided, on 3/14/2025 at 1:00 P.M., by the DON. The policy titled, Bi-Level Therapy, indicated, .Bi-level therapy is used to treat patients with obstructive sleep apnea who have difficulty tolerating CPAP. The goals of this therapy include: improved ventilation, improve quality of sleep, decrease hospitalization s, improve cognitive function, improve oxygen saturations during sleep, decrease work of breathing, and improve lung compliance. BiLevel machines are set with two pressures, Inspiratory and Expiratory A policy was provided, on 3/14/2025 at 1:00 P.M., by the DON. The policy titled, CPAP Therapy, indicated, . Continuous Positive Airway Pressure is used to treat obstructive sleep apnea. The goals of this therapy include; improve ventilation, improve quality of sleep, decrease hospitalization s, improve cognitive function, improve oxygen saturation during sleep, decrease work of breathing, and improve lung compliance 3.1-47(a)(6)

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	155582	A. Building B. Wing	03/14/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51598 Based on record review and interview the facility failed to assess a dialysis fistula for 1 of 2 residents reviewed for dialysis. (Resident 24) Findings include: A record review for Resident 24 was completed on 3/12/2025 at 9:43 A.M. Diagnoses included but were not limited to: chronic kidney disease stage 4 and fistula left wrist. A current care plan indicated Resident 24 was at risk for the dialysis fistula to become non-functioning. The interventions included but were not limited to: all fistulas will be assessed every shift and as needed for the bruit and thrill, if absent notify the doctor. The record for Resident 24, did not include a Physician's Order to assess the fistula. During an interview on 3/12/2025 at 2:34 P.M., Regional Nurse indicated the fistula should have been assessed and documented every shift. During an interview on 3/12/2025 at 2:39 P.M., LPM 6 indicated there was not an order for facility staff to assess the fistula and there was no documentation staff had been assessing the fistula. A current facility policy was provided by the Regional Nurse, on 3/13/2025 at 3:35 P.M. The policy titled, Guidelines for Post Hemodialysis Care, indicated . a licensed nurse should palpate the fistula daily for bruit/thrill and each shift the site should be assessed. 3.1-37(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately, had resident labels, and medication carts were were free of loose pills for 2 of 3 medication carts observed. (Peach Pod & Maple Pod) Findings include: 1. During a medication storage observation, on [DATE] at 10:44 A.M., with LPN 4 on the Peach medication cart, the following was observed: - An opened and undated bottled of Zinc Caps and Vit. C with no resident identifiers - An opened and undated vial of Lantus insulin. - An opened and undated Lispro insulin pen. - An opened and undated vial of Lantus insulin. - An opened bottle of betadine for a discharged resident. - A tube of neopsporin ointment with no resident identifiers. - An opened and undated bottle of ammonium lactate lotion with the resident label torn off. - One (1) loose white pill. - Four (4) opened and undated containers of [NAME] lax. - An opened and undated bottle of Tussin cough syrup. During an interview, on [DATE] at 10:57 A.M., LPN 4 indicated the medications should have been label and dated when opened. 2. During a medication storage observation, on [DATE] at 10:59 A.M., with RN 13 on the ICF Maple medication cart, the following was observed: - An unlabeled Flutisone Propionate inhaler. - An unopened bottle of timolol eye drops with no resident identifiers. - An opened and undated vial of Humalog insulin. - Two (2) boxes of assure prism solution that had expired on [DATE] and [DATE]. (continued on next page)

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	155582	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two (2) containers of Aquaphor (skin lotion) for a resident who had been expired and 1 container with no label. - An opened and undated bottle of maxi Tussin cough syrup. - Four (4) opened and undated bottles of Miralax. During an interview, on [DATE] at 11:09 A.M., RN 13 indicated the medications should have been labeled and dated when opened. On [DATE] at 1:45 P.M., the Director of Nursing provided the policy titled, Medication Storage in the Facility, dated [DATE], and indicated the policy was the one currently used by the facility. The policy indicated . Medications and biological's are stored safely, securely, and properly following manufacture or supplier recommendations . 14. Outdated, contaminated, or deteriorated drugs and those in containers .will be immediately withdrawn from stock by the facility. 15. Medication storage areas are kept clean A policy for dating and labeling medications was requested, but were not provided prior to the survey exit. 3XXX,d+[DATE](j) 3XXX,d+[DATE](o)

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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.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 38845 Based on record review and interview, the facility failed to obtain a physician ordered lab for 1 of 1 residents reviewed for laboratory services. (Resident 61) Finding includes: The record for Resident 61 was reviewed on 3/12/2025 at 10:15 A.M. Diagnoses included, but were not limited to epilepsy, depression, hypertension, atrial fibrillation, hernia and cardiomegaly. A Nursing Progress Note, dated 2/8/2025 at 11:10 P.M., indicated the resident complained of abdominal pain where a hernia was protruding. The Nurse Practitioner was notified and an order to send the resident to the hospital was received. Resident 61 was hospitalized from 2/8/2025 to 2/13/2025. The Post Acute Transfer Order sheet, date 2/13/2025, indicated Resident 61 was to have laboratory draws (blood draws) consisting of CBC (complete blood count) and a Renal Panel test in 1 week. There was no documentation of the laboratory blood draws being completed and/or the results. During an interview, on 3/12/2025 at 11:50 A.M., the Director of Nursing indicated the lab orders should have been completed. 3.1-49(a)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49994 Based on observation and interview, the facility failed to ensure recipes were followed when preparing pureed meals. This deficient practice had the opportunity to affect 4 of 4 residents who received pureed meals from the kitchen. Finding includes: During an observation of the preparation of pureed meals on 3/10/2025 at 11:41 A.M., [NAME] 2 added 4 scoops of cauliflower and an unmeasured amount of water to the mixer. She indicated she used a #8 (1/2 cup) scoop for the cauliflower and added as much water as she needed to get the correct consistency. [NAME] 2 did not use a recipe for the pureed cauliflower. During an observation of the main dining on 3/10/2025 at 12:29 P.M., Resident 14 received a pureed meal. The resident's pureed meal was watery in appearance and all of the individual food items ran together. During an observation of the preparation pureed meals on 3/13/2025 at 11:06 A.M., [NAME] 2 indicated she was preparing nine servings of mixed vegetables. [NAME] 2 added the vegetables to the mixer with an unknown measured amount of water and began mixing. [NAME] 2 added more water to the mixer and continued mixing. [NAME] 2 did not use a recipe to make the mixed vegetables. The pureed vegetables appeared very thin. She indicated she would add some thickener to the mixture prior to serving if the mixed vegetables appeared too thin after placing onto the steam table. During an interview on 3/13/2025 at 11:16 A.M., [NAME] 2 indicated she should have used a recipe when preparing the pureed meals. On 3/13/2025 at 2:05 P.M., the DON provided a policy titled, Pureed Diet, date 6/2023 and indicated it was the policy currently being used by the facility. The policy indicated .Foods are thickened if necessary to achieve a pudding or mashed potato consistency using commercial food thickeners or food items like mashed potato flakes. At times, it may be necessary to add liquid instead of thickening the food. Liquids used include: gravies, broth, juices or milk. Water is not used since it causes flavor loss then resulting in poor intake. Food characteristics: Can be piped, layered, or molded; appears softly formed on the plate. Shows some very slow movement under gravity but cannot be poured. Falls off spoon in single spoonful when tilted and continues to hold shape on plate 1.3-20(i)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49994 Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This issue had the potential to affect 83 of 83 residents who received food from this kitchen. Findings include: On [DATE] at 9:39 A.M., a kitchen tour was conducted with [NAME] 2. The following was observed in the walk-in cooler: - An opened bag of sausage gravy with a use by date of [DATE]. - An opened container of ketchup with no use by date. - An opened bag of tomato soup with a use by date of [DATE]. - An opened bag of lettuce not sealed tightly. - An opened bag of shredded cheddar cheese not sealed tightly. - An opened bag of lettuce with a use by date of [DATE]. - An opened box of hot dogs not sealed tightly. The following was observed in the walk-in freezer: - An opened bag beef of patties not sealed tightly. - An opened bag of green beans not sealed tightly. During an interview on [DATE] at 9:51 A.M., [NAME] 2 indicated the bags that were not sealed tightly should have been and the expired foods should have been thrown out. On [DATE] at 12:00 P.M., the Regional Director of Clinical Services provided a policy titled, Food Safety and Sanitation, dated ,d+[DATE] and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: The facility will show safe food handling and storage of dry foods and supplies. Opened products will be labeled and stored in tightly covered containers. Foods in the refrigerator will be covered, labeled, and dated. Foods will be used by its use by date, frozen or discarded 3XXX,d+[DATE](i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49994 Based on observation, interview and record review, the facility failed to ensure staff members followed general infection control practices regarding enhanced barrier precautions (EBP) (CNA 10 & DON) and failed to ensure an infection prevention and control program was established and maintained. Findings included: 1. During an observation on 3/11/2025 at 9:27 A.M., CNA 10 was observed in Resident 14's room without wearing a gown. There was an EBP sign on the resident's door. During an interview on 3/11/2025 at 9:33 A.M., CNA 10 indicated she was gathering the residents trash and making the resident's bed. She indicated she should have had on a gown while in the resident's room. 2. During an observation on 3/12/2025 at 1:44 P.M., the DON was observed walking into a residents room who was on EBP precautions without wearing a gown. There was an EBP sign on the resident's door. During an interview on 3/13/2025 at 1:48 P.M., the DON indicated she went into the resident's room to help the resident off the toilet. She indicated she also provided perineal care prior to placing the resident in bed. She indicated she was wearing gloves but was not wearing a gown while providing care to the resident. She indicated she should have been wearing a gown. 52118 3. During an observation, on 3/10/2025 at 3:05 P.M., CNA 3 was observed providing toileting assistance for Resident 3, who had multiple skin tears. CNA 3 donned (applied) gloves but did not don a gown. Resident 3's room door did not have a Enhanced Barrier Precautions (EBP) sign on the door. During an interview, on 3/10/2025 at 3:15 P.M., CNA 3 indicated she was aware of Resident 3's multiple skin tears, but she did not know Resident 3 was on Enhanced Barrier Precautions. The record for Resident 3 was reviewed on 3/11/2025 at 9:15 A.M. A current Physician's Order, dated 8/3/24, indicated Enhanced Barrier Precautions due to skin tears. During an interview on 3/11/25 9:30 A.M., Nurse 9 indicated she thought the resident had a sign on her door due to her skin tears. Per Centers for Disease Control (CDC), the EBP sign directs providers and staff to gown and wear gloves during high-contact care, including toileting and transfering of residents with skin wounds that require dressings. 51598 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A record review for Resident 17 was completed on 3/11/2025 at 1:26 P.M. Diagnoses included but were not limited to: Chronic Hepatitis C, carrier of carbapenum resistant Acinetobacter baumannii (CRAB), and chronic kidney disease stage 3. Physician Orders dated 1/19/2024 indicated Resident 17 was on contact precautions. A current Care Plan for Resident 17 indicated he was on contact precautions related to CRAB (a multidrug resistant infection). A sign was observed on Resident 17's door indicating staff were to apply gloves and gown before entering the room, were to perform all care while wearing gloves and gown, and dispose of linen and trash in designated receptacles. During an observation on 3/10/2025 at 10:25 A.M., a housekeeper was observed in Resident 17's room carrying a trash bag but not wearing gloves or a gown. During an observation on 3/10/2025 at 10:33 A.M., a CNA was observed making Resident 17's bed without wearing gloves or a gown. During an observation on 3/12/2025 at 9:05 A.M., a CNA was observed entering Resident 17's room without wearing gloves or a gown. During an interview on 3/11/2025 at 2:03 P.M., CNA 11 indicated that staff should have worn a gown and gloves when entering Resident 17's room. CNA 11 also indicated she should have been wearing a gown and gloves when she was making his bed. 38845 5. On 3/14/2025 at 1:06 P.M., a review of the infection log book indicated the last documentation for tracking and trending resident infections had been completed in December 2024. The book lacked the documentation to show resident infections had been monitored since December 2024. During an interview, on 3/14/2025 at 1:10 P.M., the Director of Nursing indicated the policies were reviewed annually and there had been tracking and trending done in 12/2024. She indicated there was nothing documented more recently for this year, and it should have been done. On 3/13/2025 at 2:35 P.M., the Regional Nurse provided the policy titled, Guidelines for Enhanced Barrier Precautions: An extension of Personal Protective Equipment, dated 12/2022 and indicated it was the policy currently being used by the facility. The policy indicated . Policy: It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multi-drug resistant Organisms also known as MDRO's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/14/2025 at 1:45 P.M., the Director of Nursing provided the policy titled, Guidelines for Infection Prevention and Control, dated 8/17/2023, and indicated the policy was the one currently used by the facility. The policy indicated . Surveillance: A surveillance system designed to do the following will be maintained: Identify possible communicable diseases or infections before they can spread to other persons in the facility. Ensure that any communicable diseased are identified and reported timely and to the required parties/agencies. Ensure that standard and transmission-based precautions are followed in an effort to prevent the spread of infection 3.1-18(a) 3.1-18(b)(1)