STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155617	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Chesterfield Skilled Nursing Facility	524 Anderson Rd Chesterfield, IN 46017

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide residents and/or their representatives with written notice of transfer/discharge and bed hold policy for 3 of 3 residents reviewed for hospitalizations. (Residents 2, 30, and 46) Findings include: 1.Resident 2's clinical record was reviewed on 3/25/26 at 2:17 p.m. Diagnoses included unspecified heart failure, oropharyngeal dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD).A 2/24/26, quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired and utilized a feeding tube.A 11/7/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 11/7/25, nursing progress note indicated Resident 2's blood sugar was checked and read as high. The on-call physician was contacted and provided an order to send the resident to the emergency room for evaluation and treatment.A 11/7/25, online eInteract Change in Condition assessment indicated the resident had high blood sugar and the on-call physician provided an order to send the resident to the emergency room for treatment and evaluation.A 11/8/25, online eInteract Transfer Form indicated the resident was transferred to the hospital and the emergency contacted was notified of the transfer by phone.A 11/10/25, online Indiana Bed Hold Notification form indicated the Resident 2's family was contacted and verbal acknowledgement of the bed hold policy was obtained.The clinical record lacked documentation that the resident and/or resident representatives were provided with a written copy of the transfer/discharge form and/or bed hold policy.2.Resident 30's clinical record was reviewed on 3/26/26 at 3:29 p.m. Diagnoses included Alzheimer's Disease, chronic atrial fibrillation, and major depressive disorder.A 2/27/26, annual MDS assessment indicated Resident 30 was moderately cognitively impaired.A 12/8/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 12/8/25, social services note indicated Resident 30 was upset after returning from a visit with family outside of the facility. Resident 30 verbalized self-harm concerns to staff and was placed on 1 to 1 care. The nurse practitioner (NP) was contacted and provided an order to send a referral to a psychiatric hospital for evaluation and treatment. The resident's family was notified and agreeable to the transfer.A 12/8/25, online eInteract Change in Condition assessment indicated Resident 30 experienced suicidal ideation and increased confusion. She was sent to the emergency room for evaluation and treatment. The emergency room was to send the resident to the psychiatric hospital for treatment. Resident 30's daughter was contacted.A 12/8/25, online eInteract Transfer Form indicated the resident was discharged to the hospital and her daughter was contacted by phone.A 12/8/25, online Indiana Bed Hold Notification form indicated the Resident 30's family was contacted and verbal acknowledge of the bed hold policy was obtained.The clinical record lacked documentation that the resident and/or resident representatives were provided with a written copy of the transfer/discharge form and/or bed hold policy.3.Resident 46's clinical record was reviewed on 3/27/26 at 9:27 a.m. Diagnosis included type 2 diabetes mellitus, hyperlipidemia, and paroxysmal atrial fibrillation.A 1/6/26, quarterly MDS assessment indicated the resident was cognitively intact.A 3/9/26, discharge MDS assessment indicated the resident discharged with a return anticipated. A 3/9/26, nursing progress note indicated Resident 46 complained of nausea, vomiting, was shaking, and had blood in his urinary catheter. The (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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP was contacted and an order to send him to the emergency room for evaluation and treatment was obtained. The resident's spouse was contacted by phone and a voicemail was left.A 3/9/26 online eInteract Change in Condition assessment indicated Resident 46 was sent to the emergency room for abnormal vitals signs, bleeding, and a change of condition. The resident and his wife were notified.A 3/9/26, online eInteract Transfer Form indicated staff contacted the emergency room to give report and the resident's wife was notified.A 3/9/26, online Indiana Bed Hold Notification form indicated the Resident 46's wife was contacted and verbal acknowledge of the bed hold policy was obtained.The clinical record lacked documentation that the resident and/or resident representatives were provided with a written copy of the transfer/discharge form and/or bed hold policy.A 10/16/25 discharge MDS assessment indicated the resident discharged with a return anticipated. A 10/16/25, nursing progress note indicated Resident 46 had low urine output and abnormal lab values. The NP provided an order to send him to the emergency room for evaluation and treatment.A 10/16/25, online eInteract Change in Condition assessment indicated an abnormal lab value. Resident 46's wife was notified.A 10/16/25, online eInteract Transfer Form indicated the staff contacted the emergency room to give report and the resident's wife was notified.A 10/16/26, online Indiana Bed Hold Notification form indicated the Resident 46's wife was contacted and verbal acknowledge of the bed hold policy was obtained.The clinical record lacked documentation that the resident and/or resident representatives were provided with a written copy of the transfer/discharge form and/or bed hold policy.During an interview, on 3/27/26 at 2:19 p.m., LPN 6 indicated the nursing station had a cheat sheet to help staff remember all the steps for discharging a resident. She would complete a full assessment and obtain a full set of vitals. She would gather as much information about the situation and contact the physician or NP to obtain an order to send the resident to the emergency room. She would call 911. She would print out the resident specific documents such as the face sheet, code status, medication list, and a bed hold policy. She would complete the online eInteract forms, makes a progress note, add the order to send the resident out to the emergency room, and contact the resident's family. Once the ambulance arrives, she gives the packet containing the resident information forms to the Emergency Medical Technicians (EMTs). She calls report to the hospital and obtains the fax number to send the resident information paperwork directly.On 3/27/26 at 2:29 p.m., LPN 7 indicated when a resident needed to be sent out to the emergency room, she would complete a full assessment and obtain vitals signs. She would call the NP or on-call physician to obtain an order to send the resident to the emergency room. She would call 911. She would complete the online Change in Condition form and print out the resident specific documents such as the face sheet, medication list, post form, and bed hold policy. She would meet the EMT's and assist them as needed. She gives the resident documents to the EMT's as they are leaving the facility. She would call the hospital to give report and notify the resident's family.During an interview, 3/30/26 at 11:28 a.m., the DON indicated when a resident needs to be transferred to the emergency room, the nurse would contact the NP or on-call physician to obtain an order. The nurse would assess the resident and complete the online eInteract Change in Condition form and the eInteract Transfer Form. The nurse would contact the family and print out resident documents such as the face sheet, post form, and physician's orders. This information was given to the EMTs. The nurse would call report to the receiving emergency room. The resident and/or resident representative should get a bed hold policy paper and then this would be documented on the online eInteract Indiana Bed Hold form.During an interview, on 3/30/26 at 12:28 p.m., the Administrator indicated the facility completed the transfer/discharge forms and bed hold notifications online. They have not been printing out any of the online transfer/discharge forms or bed hold notifications to provide to the resident or resident representatives. She indicated she had no further documentation to provide for Residents 2, Resident 30, or Resident 46.An undated, current facility policy, titled, Transfer and Discharge Policy Procedure, provided by the DON on 3/30/26 at 3:30 p.m., indicated the following: . 6. Explain transfer and reason to the resident and/or representative if applicable send the Original State Transfer/Discharge/Bed Hold Notice with the resident and/or representative or (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person(s) responsible for care. Place the facility copy in the health record. 7. Complete the Resident Transfer for 2 copies of any portion of the health record necessary for the care of the resident. 8. Send original of the transfer form and portions that was copied with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer form to the DON. 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(A)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to follow enhanced barrier precautions (EBP) during medication administration for 1 of 1 resident reviewed for tube feedings. (Resident 2)Findings include:Resident 2's clinical record was reviewed on 3/25/26 at 2:17 p.m. Diagnoses included unspecified heart failure, oropharyngeal dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD).Current orders include the following: EBP related to PEG (gastrostomy) tube for infection prevention (1/14/26).A 2/24/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired and utilized a feeding tube.A 2/12/26, EBP care plan indicated for staff to follow the EBP guidelines when providing care and coming into direct contact with potentially infected materials or devices. Direct care activities include device use such as feeding tubes. Interventions included reinforcing proper handwashing and following personal equipment protocols (2/12/26) and set up isolation per facility protocol, following EBP guidelines (2/12/26).During a medication administration observation, on 3/26/26 at 9:27 a.m., LPN 5 completed hand hygiene and gathered the following supplies: some paper towels, two plastic cups with 30 milliliters (mL) of warm water in each, and the resident's liquid potassium medication. LPN 5 entered the resident's room and placed the supplies on the bedside table. She paused the resident's tube feed pump and entered the resident bathroom where she donned a pair of gloves. LPN 5 leaned her hips and thighs against the resident's bed and bedsheets and spoke with her. LPN 5 checked the g-tube for residual purposes and examined the g-tube site. LPN 5 flushed the tube with 30 mL of warm water, then administered the potassium medication, and flushed the tube again, with another 30 mL of warm water. She restarted the tube feeding, gathered up the trash, and removed her gloves. LPN 5 remained leaning against the resident's bed and bedsheets through the whole medication administration process.During an interview, at the time of the observation, LPN 5 indicated the EBP sign to the resident's door indicated that staff needed to wear personal protective equipment (PPE) to help prevent the spread of infection. Resident 2 had a g-tube and staff needed to wear a gown and gloves when providing direct patient care. LPN 5 indicated she had simply forgotten to put on the gown prior to the medication administration.During an interview, on 3/20/26 at 11:28 a.m., the DON indicated that EBP was utilized when a resident has any lines, wounds, or catheters. EBP helps to protect the residents from the spread of infection. Resident 2 had and g-tube and all staff members need to wear the appropriate PPE when proving direct contact care. LPN 5 should have worn a gown during the medication administration observation.A current facility policy, last revised 12/22, titled, Guidelines for Enhanced Barrier Precautions -(EBP) An extension of Personal Protective Equipment (PPE), provided by the DON on 3/30/26 at 10:20 a.m., indicated the following: . Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high- contact resident care activities that generate opportunities for transfer of MDRO's in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver. Who is at ?high risk' for acquiring or spreading a MDRO.c.) Feeding Tubes (any type) .Examples of ?high contact' resident care activities at which time EBP is to be practiced are. g.) Device care of Use of to include. Feeding tubes (any type) .410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)