

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2025
NAME OF PROVIDER OR SUPPLIER  Waters of Wabash Skilled Nursing Facility West		STREET ADDRESS, CITY, STATE, ZIP CODE  1720 Alber St Wabash, IN 46992	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to promote resident dignity during transportation following a shower in the shower room for 1 of 3 residents reviewed for dignity. (Resident F) Findings include: Resident F's clinical record was reviewed on 10/15/25 at 9:55 a.m. Diagnoses included stroke affecting right non dominant side, mild intellectual disability, weakness, unsteadiness on feet, and cognitive communication deficit. An 8/11/25, admission, Minimum Data Set (MDS) assessment indicated she used a walker and wheelchair. She had upper extremity impairment on one side of her body. She was substantial/ maximal staff assistance for showering, upper and lower body dressing, toileting hygiene and tub/shower transfer. A progress note, on 8/6/25 at 10:40 p.m., indicated Resident F had fallen forward from the shower chair while coming out of the shower. The right front wheel fell off the shower chair causing Resident F to fall forward. Resident F hit her head on the floor causing a laceration above her right eye. Resident F did not lose consciousness and remained alert. She was sent to the emergency room (ER) for evaluation. The resident's representative and NP were notified. A progress note, on 8/30/25 at 11:15 p.m., indicated Resident F returned from the ER via emergency medical service (EMS). Resident F was assisted to bed, alert and oriented. She had seven sutures placed above her right eye brow area. During an interview, on 10/15/25 at 11:47 a.m., RN 6 indicated a staff member propelled Resident F out of the shower room into the hallway, when the front right wheel fell off the shower chair causing Resident F to fall forward onto the floor. Resident F had a laceration to her forehead. Pressure was applied and Resident F was sent to the ER for evaluation. Resident F was not transferred via mechanical lift. After this incident, they stopped transporting Resident F in the shower chair. Some staff members transferred other residents down hallway in the shower chairs. During an interview, on 10/15/25 at 1:53 p.m., the Administrator and DON indicated residents who did not require a mechanical lift for transfers should not be transported down the hallway in a shower chair. During an interview, on 10/15/25 at 2:49 p.m., QMA 7 indicated she assisted Resident F out of the shower room in the shower chair. The shower chair's right front wheel caught a divot in the floor, which caused the wheel to fall off and Resident F to fall forward onto the floor. She felt that it was fine to transfer Resident F down the hallway in a shower chair. She now knew she shouldn't transport residents down the hallway in a shower chair unless the resident transferred by a mechanical lift. Resident F required two-person staff assist and didn't need to be transferred by a mechanical lift. During an interview, on 10/15/25 at 3:02 p.m., the Administrator indicated residents should not be transported in a shower chair down the hallway unless the resident required a mechanical lift. On 10/15/25 at 3:10 p.m., the Administrator was unable to provide a policy in regard to transporting residents in a shower chair down the hallways. The Indiana Nurse Aide Training Program Core Curriculum accessed on 10/15/25 at <a href="https://www.in.gov/health/ltc/aide-training-and-certification/cna/nurse-aide-training-program-core-curriculum/">https://www.in.gov/health/ltc/aide-training-and-certification/cna/nurse-aide-training-program-core-curriculum/</a>, indicated the following: .PROCEDURE #32: SHOWER/SHAMPOO STEP RATIONALE 1. Do initial steps. 2. Clean/disinfect shower area and shower chair as per facility policy. Prep the bathing area per facility policy. Gather supplies and take them into the shower area. 2. Reduces pathogens and prevents spread of infection. Have the supplies ready when you bring the resident in the shower room to ensure resident safety. 3. Help resident remove clothing. Provide resident privacy 3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm. 4. Turn on water and have resident check water temperature for comfort, if able. 4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature. 5. Assist resident into shower via wheelchair. Lock wheels of shower chair and transfer resident to shower chair. Use safety belt to secure resident stability, if indicated. Never take your eyes off the resident or turn your back to the resident while in the shower 5. Chair may slide if resident attempts to get up. Ensure resident safety at all times. Never transport resident in shower chair. This citation relates to Intake 2633792.3.1-45(2)</p>		