STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wabash Skilled Nursing Facility West	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50721 Based on observation, interview, and record review, the facility failed to provide assistance with eating for 1 of 1 reviewed for ADLs. (Resident B) Finding includes: During a dining observation, beginning on 7/16/24 at 11:57 a.m., Resident B had not eaten any of her lunch as of 12:41 p.m. Her eyes were closed, and she had a utensil in her hand. At 12:45 p.m., QMA 6 picked up the resident's spoon and offered the resident green beans. During an interview following the observation, QMA 6 indicated Resident B was able to feed herself, but had insomnia and fell asleep frequently during the day and required reminders to eat. QMA 6 first prompted her to eat at 12:45 p.m. During an observation, on 7/17/24 at 8:41 a.m., four residents were in the dining room. No staff were present. Resident B was talking incoherently and fidgeting with her glasses. She had eaten a few bites of eggs. Housekeeper 4 entered the dining room at 8:46 a.m. and indicated that at least one nursing staff was required to be in the dining room until all the residents were done eating. She indicated staff was instructed to leave Resident B in the dining room until she was done eating. Eventually they will just take her tray. Nursing staff entered at 8:54 a.m. and escorted individual residents out of the dining room. Resident B was alone in the dining room, with a tray in front of her from 8:55 a.m. until 8:58 a.m. During an interview on 7/17/24 at 2:55 p.m., Dining Staff 3 indicated Resident B had been in the dining room alone several times. A few weeks prior, Dining Staff 3 reported to work at 11:00 a.m. and Resident B was sitting in the dining room with her breakfast tray still in front of her. During an interview, on 7/18/24 at 2:50 p.m., QMA 6 indicated Resident B was left in the dining room after dinner unattended on more than one occasion. Staff knew they were not allowed to leave residents unattended in the dining room while they were still eating. Dinner routinely ended at 6:00 p.m. and Resident B was left alone in the dining room until 8:00 p.m. The resident was not routinely prompted to eat or assisted with meals. The resident frequently picked at her food and fell asleep. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's medical record was reviewed on 7/18/24 at 12:03 p.m. Diagnoses included unspecified psychosis not due to a substance or known physiological condition; unspecified lack of coordination; unspecified insomnia; need for assistance with personal care; Alzheimer's disease; muscle wasting and atrophy of bilateral upper extremities, not elsewhere classified; generalized muscle weakness and lack of coordination. A quarterly Minimum Data Set (MDS) dated [DATE], indicated the resident had moderate cognitive impairment and required partial to moderate assistance to eat. Resident B's current care plan, dated 4/6/22, indicated the following: ADLs (Activities of Daily Living) fluctuate and amount of assist required fluctuates . I need set-up/supervision assist with eating/drinking . assist at meals with tray set-up and meals/eating as needed .give verbal cues and encourage to eat as needed (interventions dated 11/5/19) .I am at risk for aspiration. History of CVA (cerebral vascular accident or stroke) in 2014; Swallowing difficulties; history of pocketing food, long history of choking on foods/spitting . monitor for coughing or choking with meals A review of Resident B's documentation of her percentage of meals eaten, dated 6/19/24 through 7/18/24, indicated she consumed 0-25% of her food during 30 meals, 26-50% of her food during 18 meals, 51-75% of her food during 30 meals, and more than 76% of her meals during 9 of a total of 88 meals consumed. She refused one meal. Resident B's Self Performance for eating evaluation, for the same dates, indicated at a minimum, she required supervision including oversight, encouragement or cueing for 82 of 88 meals. A current, undated policy, provided by the Director of Nursing (DON) on 7/18/24 at 5:05 p.m., titled Mealtime Observation indicated: .Guideline: Residents shall be observed during mealtimes to monitor .intake of food and beverage items. Appropriate replacements/substitutions will be offered when needed. Procedure: 1. The dining room shall be monitored by the Dining Services Manager or designee at all mealtimes . 3. Nursing staff will be readily available during mealtimes, in the dining room . 5. Substitutions shall be provided for all residents when poor food/fluid intake is noted The Federal tag relates to Complaint IN00434626. 3.1-38(a)(2)(D)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48384 Based on observation, record review, and interview, the facility failed to ensure staff information was posted in a prominent place, was readily accessible to residents and visitors, and was in a clear and readable format. Findings include: On 7/15/24, at 11:32 a.m., staffing information was not readily available at the nurses station towards the front doors of the facility. No information was available on the walls at the front of the facility. The front of the building was the main entrance into the facility. On 7/15/24, at 11:41, during an interview with the Administrator (Adm), she indicated the staff posting was on the wall outside of the Director of Nursing's (DON) door. The DON's office was located in the west hall of the facility, past the nurses desk, through a doorway, and on the left side of the hallway. On 7/16/24, at 12:05 p.m., nurse staffing was posted outside the DON's door. There were two plastic sleeves that contained two 8.5 x 11 sheets of paper with staffing information. The two documents were positioned on their sides. In order to view the documents, they had to be removed from the eye-level hooks where they were hung, and repositioned to an upright orientation in order to be read. The font was small, approximately a 10 or 12 font size. During an interview with the DON, on 7/18/24 at 12:39 p.m., she indicated she thought the posting location was fine. She had been instructed by the Administrator to move the postings to a publicly accessible location at the front of the facility. A document titled Guidelines for BIPA Staffing Posting Requirement, revised on 7/24/23, and provided by the DON on 7/18/24 at 5:05 p.m., included the following information: .4) Posting Requirements: a) Data must be posted in a clear, readable format with a font of 14 or above. b) Data must be in a conspicuous prominent location, accessible to residents/visitors

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48384 Based on observation, interview, and record review, the facility failed to provide food that was attractive and palatable. (Residents 5, 15, 18, and 21) Findings include: During an interview on 7/15/24 at 11:08 a.m., Resident 18 indicated she was not feeling well. She thought her blood glucose might be low. She had not eaten any breakfast that morning because she .could not face another peanut butter and jelly sandwich She described the food as awful. She complained repeatedly to the administrator and other staff about the palatability of the food. She finally resorted to eating peanut butter and jelly sandwiches because that was the only thing she could tolerate. Carbohydrates were too many and there was not enough protein provided. The food was not properly seasoned and not appealing in appearance. During an interview on 7/18/24 at 10:42 a.m., Resident 5 indicated the food palatability varied. Sometimes the food was not bad, but other times it was not edible. It all depended on who was working in the kitchen. During an interview on 7/15/24 at 11:23 a.m., Resident 21 indicated the food was not good, sometimes not hot, and unappealing. During an interview on 07/15/24 at 3:12 p.m., Resident 15 indicated the food was sometimes bad . sometimes good, depending on who was working in the kitchen. Information gathered at a Resident Council Meeting on 7/17/24 at 3:04 p.m. included the following: Resident 21 indicated improperly cooked shrimp had been served twice. Resident 15 indicated she would taste what was being served for eating breakfast - eggs were often cold and the oatmeal was too thick. During an observation of dining on 07/16/24 at 12:26 p.m. a resident was overheard saying the chicken was actually soft, that she could actually eat it. At 12:43 p.m., another resident was observed sending her hamburger back to the kitchen because it was cold. A test lunch tray was provided on 7/16/24 at 1:10 p.m. The menu for the day included Dijon chicken, rosemary roasted potatoes, green beans, and chocolate pudding. The chicken was appropriately cooked, was warm (not hot), and was seasoned slightly. There was no Dijon taste to the chicken. The rosemary roasted potatoes, light gray to dark gray in color, were grease soaked and mushy. They tasted like grease. The rosemary could be detected but there were no other seasonings. The green beans were from a can and no salt or any other seasoning had been added. They were flavorless and mushy. The chocolate pudding was lumpy and not thoroughly mixed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 7/17/24 at 4:02 p.m., she indicated one resident complained frequently about too much pepper on the food. Another resident had complained about a curry soup. She was not aware of other residents complaining about the look and taste of the food. She did not encourage the kitchen staff to taste the food before serving it because she wanted to avoid cross-contamination. No policy addressing food attractiveness or palatability was provided. 3.1-21 (a)(1)(2)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48384 Based on observation, interview, and record review, the facility failed to provide a nourishing snack at bedtime when there was more than fourteen (14) hours between the evening meal and breakfast the next day. This had the potential to affect twenty four (24) out of twenty four (24) residents. (Residents 3, 16, 15, 18, 21, and 22) Findings include: During a resident council meeting on 7/17/24 at 3:04 p.m., Resident 15 indicated the facility used to provide snacks in the evening. Eventually, the snacks provided were only oatmeal pies. The night before the meeting, there were no snacks available at all. Resident 21 indicated the facility sometimes provided goldfish, oatmeal pies, or a sandwich. If the facility would run out of snacks, the residents did not get an evening snack. Resident 15 indicated residents would sometimes ask a kitchen staff member to hold food items for them. The staff member would do so. All residents present at the council meeting indicated snacks were not offered in the evenings. They could get snacks only when they asked for them and often, no snacks were available. During an interview with CNA 5 on 7/18/24 at 2:50 p.m. she indicated residents could get a snack at bedtime if they asked. The problem was there were no snacks to pass out to the residents. The residents used to get chips and cookies. Now, they could barely get cookies. She had, on occasion, gone to the grocery store to buy granola bars because there were no snacks available. The facility did not provide peanut butter crackers or even oatmeal cookies. They did sometimes have sandwichest, but those could be up to four (4) days old. The sandwiches were soggy and mushy. Most of the residents on the [NAME] hall wanted snacks. When they were available, snacks could be found in the therapy room refrigerator or cabinets. An untitled document, provided by the Business Office Manager (BOM), on 7/15/24 at 3:36 p.m., indicated mealtimes at the facility were as follows: Breakfast - 7:30 a.m., Lunch - 12:00 p.m., and Dinner - 5:00 p.m. The time between dinner and breakfast the next day was fourteen and a half (14.5) hours. During an interview with the Administrator on 7/17/24 at 4:02 p.m., she indicated snacks were provided to the residents and kept in the refrigerator in the therapy room. Snacks were passed with medications at night. Residents could have a snack any time of day they wanted. In addition to sandwiches in the refrigerator, residents could have crackers and cookies. To tell a resident snacks were unavailable was not acceptable. No policy referencing evening or bedtime snacks was provided by the facility. 3.1-21(d) and (e)

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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. 48384 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 5 residents reviewed for EBP (Resident 21) Findings include: Resident 21's clinical record was reviewed on 7/16/24 at 3:25 p.m. Diagnoses for the resident included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, morbid (severe) obesity due to excess calories, and non-pressure chronic ulcer of other part of left foot with unspecified severity. Current physician orders included, but were not limited to: 6/7/24 - An external ointment, mupirocin 2%, was to be applied to the left great toe topically every day and night shift. The wound was to be covered with dry, sterile gauze. 5/14/24 - A weight bearing as tolerated (WBAT) surgical shoe to be worn on the left foot. 5/6/24 - Monitor the left great toe each shift for signs and symptoms of infection, dressing placement, and surrounding tissue until healed. 2/8/24 - Notify the physician of any foul-smelling odor, red streaking up the leg, discolored drainage, and watch for infection, every shift. During an observation, on 5/17/24 at 11:23 a.m., Resident 21 was in her room. She was wearing disposable booties over her socks. Drainage was observed on the disposable bootie. The resident indicated she had a diabetic ulcer on the bottom of her toe. She could see the drainage on the bootie. The room had no signage, inside or outside, to indicate the resident required EBP. No personal protective equipment (PPE) was available inside or outside the room. During an observation on 5/17/24, at 1:42 p.m., Resident 21 indicated the nurse had put on a new bootie but did not change the dressing. She indicated the nurses providing dressing changes to her foot did not wear gowns when providing care. During an observation on 7/16/24, at 9:30 a.m., the wound care nurse and the DON performed a dressing change on Resident 21's left great toe. The DON provided hands-on care while the wound care nurse measured the wound. Both nurses donned gloves before providing care. No gowns were donned before or during the procedure. The wound care nurse indicated the wound was a full-thickness, diabetic foot ulcer. During an interview with the corporate nurse consultant, on 7/17/24 at 11:15 a.m., she indicated EBP should be used for residents with catheters and wounds. She was not aware of any residents with wounds in the facility. She was not aware EBP was not being followed for Resident 21. PPE should be available in the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 7/18/24 at 12:38 p.m., she indicated Resident 21 should be on EBP. A document, titled Guidelines for Enhanced Barrier Precautions (EBP) - An extension of Personal Protective Equipment (PPE), with a revision date of 12/2022, was provided by the Administrator on 7/17/24 at 4:02 p.m. The document indicated it was the policy of the facility to ensure that additional and appropriate PPE is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms, also known as MDROs. Enhanced Barrier Precautions (EBP) are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of a MDRO or a colonized MDRO. These precautions are generally in place for the duration of the resident's stay, or until there is a resolution of the wound or discontinuation of the device that placed the resident at 'higher risk' .Examples of 'high contact' resident care activities at which time EBP is to be practiced are: a) dressing care/changes/management of dressings . Procedure: .3) Ensure that proper signage is posted on the resident's room door instructing those who plan to enter the room to check first at the nurses' station for education/instructions. 4) Ensure that all necessary supplies are available in an enclosed clean labeled container outside thee resident's room 3.1-18(a)