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	08/07/2025

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 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 and interview, the facility failed to ensure staff performed hand hygiene during 3 of 3 medication administration observations. (Resident 13, Resident 3, and Resident 12)Findings include:During a medication administration observation on 8/6/25 at 11:09 a.m., Qualified Medication Aide (QMA) 4 removed one medication for Resident 13 from the [NAME] Hall medication cart. Prior to removing the medication, the QMA did not perform hand hygiene. She popped one pill from a blister pack into a medication cup and poured water into a plastic drinking cup. QMA 3 entered Resident 13's room and administered the medication. The QMA did not perform hand hygiene during the observation.During a medication administration observation on 8/6/25 at 11:13 a.m., QMA 4 removed one medication for Resident 3 from the [NAME] Hall medication cart. Prior to removing the medication, the QMA did not perform hand hygiene. She popped one pill from a blister pack into a medication cup and poured water into a plastic drinking cup. QMA 4 entered Resident 3's room, administered the medication, then exited the room. The QMA did not perform hand hygiene during the observation.During a medication administration observation on 8/6/25, at 11:19 a.m., QMA 4 removed one medication for Resident 12 from the [NAME] Hall medication cart. Prior to removing the medication, the QMA did not perform hand hygiene. She popped one pill from a blister pack into a medication cup and poured water into a plastic drinking cup. QMA 4 entered Resident 12's room, administered the medication, then exited the room. The QMA did not perform hand hygiene during the observation.During an interview with QMA 4 on 8/6/25, at 11:27 a.m., she indicated she forgot to use hand sanitizer before passing medications.During an interview with the Director of Nursing (DON) on 8/7/25 at 3:47 p.m., she indicated staff should perform hand hygiene before and after administering medications to residents.A current facility policy, titled Medication Administration, provided by the Administrator on 8/6/25 at 1:45 p.m., indicated the following: .Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis .Before the medication pass .2) Cleanse your hands before beginning and before contact with each resident 3.1-18(a)(l)

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