STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterford Place Health Campus	800 St Joseph Dr Kokomo, IN 46901

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when the resident had a new mental health diagnosis and was prescribed an antipsychotic medication for 1 of 3 residents reviewed for PASARR. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 1/28/26 at 12:27 p.m. The diagnoses included, but were not limited to, depression, atrial fibrillation, heart disease, vascular dementia, pseudobulbar affect, post-traumatic stress disorder (PTSD), and adjustment disorder with anxiety.A physician's order, dated 9/19/25, indicated to administer diazepam (an antianxiety medication) 2 mg (milligram) twice a day. A PASARR level I screen related to the diagnosis of anxiety disorder, and the new medication was not completed until 2/2/26 after the start of the survey.During an interview, on 2/2/26 at 3:39 p.m., the Administrator indicated when a resident had a new psychotic medication or a new mental health diagnosis added, a new level I needed to be completed. The resident did not have a new level I completed until 2/2/26 to add the diazepam. A current facility policy, titled PASARR Quick Sheet, undated and received from Clinical Support on 2/2/26 at 1:39 p.m., indicated .New Admissions: If any of the following triggers a positive response.contact the PASARR office .Individual has a severe mental illness/behavioral health (BH) diagnosis. ex. Schizophrenia, Bipolar Disorder, Major Depression Disorder, Anxiety Disorder .These diagnoses must be given by a Psych MD/ARNP and not by a PCP or some other type of treatment provider other than psychiatry 3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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 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** Based on interview and record review, the facility failed to ensure daily weights were obtained as ordered by the physician, admission weights were obtained in a timely matter, and the physician was notified according to the physician's order for 4 of 4 residents reviewed for quality of care. (Resident 3, 93, 10 and 94)Findings include:1. The clinical record for Resident 3 was reviewed on 1/29/26 at 1:52 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease with exacerbation, heart failure, fluid overload, chronic kidney disease, and acute pulmonary edema. A physician's order, dated 12/2/25, indicated to obtain a daily weight once a day. A care plan, dated 12/3/25, indicated to obtain a weight as ordered. The Medication Administration Record (MAR), dated 12/1/25 to 12/31/25, indicated the daily weight was not obtained and documented on 12/2/25, 12/3/25, 12/6/25, 12/9/25, 12/12/25, 12/15/25, 12/24/25, 12/26/25 and 12/31/25. The MAR, dated 1/1/26 to 1/31/26, indicated the daily weight was not obtained and documented on 1/1/26, 1/8/26, 1/12/26, 1/15/26, 1/17/26, 1/18/26, 1/19/26, 1/22/26, 1/23/26, 1/24/26, 1/27/26, 1/28/26 and 1/29/26. During an interview, on 2/2/26 at 3:10 p.m., QMA 2 indicated daily weights should be completed every day, usually in the morning before breakfast. During an interview, on 2/2/26 at 3:39 p.m., the Director of Nursing (DON) indicated daily weights should be completed every day. 2. The clinical record for Resident 93 was reviewed on 1/30/26 at 10:50 a.m. The diagnoses included, but were not limited to, severe protein-calorie malnutrition, encephalopathy, pneumonia, rhabdomyolysis, atherosclerotic heart disease, ischemic cardiomyopathy, repeated falls, hypovolemic shock, and gastrostomy status. Resident 93 was admitted to the facility on [DATE]. A physician's order, dated 1/20/26, indicated to obtain an admission weight. A physician's order, dated 1/21/26, indicated to obtain an admission weight. The clinical record indicated an admission weight of 106.5 pounds was obtained on 1/26/26 at 3:40 p.m. The admission weight was not documented until 6 days after admission. During an interview, on 2/2/26 at 3:10 p.m., QMA 2 indicated admission weights should be completed as soon as the resident arrived at the facility on the day of admission. During an interview, on 2/2/26 at 3:39 p.m., the DON indicated admission weights should be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed within 24 hours of admission. Resident 93's admission weight should have been completed sooner. 3. The clinical record for Resident 10 was reviewed on 1/28/26 at 2:54 p.m. The diagnoses included, but were not limited to, diabetes mellites and a fracture of the upper and lower end of right fibula. A care plan, dated 12/28/23, indicated the resident received hypoglycemia medication and was at risk for adverse effects. Interventions included, but were not limited to, to administer medication as ordered. A physician's order, dated 8/7/25, indicated to administer Humalog insulin per the sliding scale and to call the physician for a blood sugar less than 60 or greater than 400. The clinical record indicated the resident's blood sugar was 435 on 9/19/25 at 7:09 p.m. An Interdisciplinary Team (IDT) note, dated 9/22/25 at 10:41 a.m., indicated the Nurse Practitioner was notified of the resident's elevated blood sugar. During an interview, on 1/30/26 at 2:24 p.m., the Clinical Support Nurse indicated the Director of Nursing (DON) did not notify the physician until days later, on 9/22/25. During an interview, on 2/2/26 at 3:13 p.m., RN 3 indicated when a resident had an order for sliding scale insulin the order was to be followed. When the resident's blood sugar was out of range, the Nurse Practitioner (NP) would be notified. The NP could want to add additional insulin. 4. The clinical record for Resident 94 was reviewed on 1/28/26 at 3:22 p.m. The diagnoses included, but were not limited to, history of urinary tract infection and history of cerebrovascular accident. Resident 94 was admitted to the facility on [DATE]. The clinical record indicated an admission weight of 165.0 pounds was obtained on 1/30/26 at 11:12 a.m. During an interview, on 1/30/26 at 11:24 a.m., the Medical Record Nurse indicated when a resident was admitted to the facility the nurse should obtain an admission weight within 24 hours. A current facility policy, titled Guidelines for admission Nursing Observation and Data Collection, dated as last reviewed 12/10/25 and received from the Clinical Support Nurse on 2/3/26 at 3:30 p.m., indicated .To complete and document a comprehensive assessment of the resident's current medical status, identify risk factors for additional complications or safety concerns and implement a temporary plan of care to address problem areas .The admission Observation and Data Collection form is to be completed in electronic health record by a licensed nurse .The comprehensive head to toe observation and data collection addresses each body system and shall be initiated within 12 hours and completed within 24 hours of admission A current facility policy, titled Clinical Services - Weight Monitoring, dated as last reviewed 7/3/25 and received from the Clinical Support Nurse on 2/3/26 at 3:30 p.m., indicated .The purpose of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this policy is to ensure weight monitoring to promote well-being of the residents we serve and requires a multidisciplinary approach .Daily review of missing admission weights in CCM .May be reviewed by clinical leaders .Provide a list of missing weights to floor staff to obtain .Review of missing weights: Daily Weights as ordered .May be delegated to clinical leaders .Provide a list of missing monthly weights to floor staff to obtain .Review of error weights, daily, in CCM 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure a catheter bag and tubing were maintained in a sanitary manner for 1 of 2 residents reviewed for catheters. (Resident 11) Findings include: During an observation, on 1/30/26 at 11:13 a.m., Resident 11's catheter was attached to the trash can next to the bed. The urine in the catheter tubing was cloudy with sediment (matter which settles to the bottom of liquid). The trash can had trash in the bottom. The clinical record for Resident 11 was reviewed on 1/28/26 at 10:22 a.m. The diagnoses included, but were not limited to, history of urinary tract infection (UTI), acute kidney failure, anxiety disorder, chronic pain syndrome, hypertension, heart failure, chronic obstruction pulmonary disorder, retention of urine, and atrial fibrillation.A care plan, dated 5/30/24, indicated Resident 11 had a Foley catheter related to the diagnosis of neurogenic bladder. Interventions included, but were not limited to, observe the catheter tubing.A recently completed physician's order, dated 12/27/25, indicated to administer ciprofloxacin (an antibiotic) 500 milligrams two times a day for 14 days for a UTI.During an interview, on 1/30/26 at 11:19 a.m., the Assistant Director of Nursing (ADON) indicated the catheter bag should not be placed on the trash can. The resident had a history of urinary tract infection (UTI) and a catheter bag on the trash can contribute to infection. During an interview, on 1/30/26 at 11:21 a.m., the Medical Record Nurse indicated the catheter bag was not supposed to be on the trash can and the resident was at risk of infection.During an interview, on 1/30/26 at 11:30 a.m., Qualified Medical Assistant (QMA) 6 indicated the catheter bag should be hung on the bed rail and never on the trash can. When you hang the bag on the dirty trash can, the resident would be at risk of developing a major infection. A current facility policy, titled Urinary Catheter Care, dated as last reviewed 12/16/24 and received from the Clinical Support nurse on 2/3/26, indicated .Check the urine for unusual appearance .The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .Check the resident frequently to be sure he/she is not lying on the catheter and to keep the catheter and tubing free of kinks 3.1-41(a)(2)

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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, interview and record review, the facility failed to ensure infection control practices were followed for 1 of 1 randomly observed resident reviewed for infection control. (Resident 11) Findings include:During an observation, on 1/30/26 at 11:13 a.m., Resident 11's catheter was attached to the trash can next to the bed. The urine in the catheter tubing was cloudy with sediment (matter which settles to the bottom of liquid). The trash can had trash in the bottom. The clinical record for Resident 11 was reviewed on 1/28/26 at 10:22 a.m. The diagnoses included, but were not limited to, history of urinary tract infection (UTI), acute kidney failure, anxiety disorder, chronic pain syndrome, hypertension, heart failure, chronic obstruction pulmonary disorder, retention of urine, and atrial fibrillation.A recently completed physician's order, dated 12/27/25, indicated to administer ciprofloxacin (an antibiotic) 500 milligrams two times a day for 14 days for a UTI.During an interview, on 1/30/26 at 11:19 a.m., the Assistant Director of Nursing (ADON) indicated the catheter bag should not be placed on the trash can. The resident had a history of urinary tract infection (UTI) and a catheter bag on the trash can contribute to infection. During an interview, on 1/30/26 at 11:21 a.m., the Medical Record Nurse indicated the catheter bag was not supposed to be on the trash can and the resident was at risk of infection.During an interview, on 1/30/26 at 11:30 a.m., Qualified Medical Assistant (QMA) 6 indicated the catheter bag should be hung on the bed rail and never on the trash can. When you hang the bag on the dirty trash can, the resident would be at risk of developing a major infection. A current facility policy, titled Infection Prevention and Control Program, not dated and received during entrance on 1/27/26, indicated .To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .monitors compliance with infection control practices and procedures 3.1-18(b)(1)