STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155150	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Columbia City Skilled Nursing Facility	640 W Ellsworth St Columbia City, IN 46725

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(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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure dignity was provided during meal service for 6 of 14 residents seated together in the main dining room (Resident 49, Resident 3, Resident 31, Resident 1, and Resident 36).Findings include:During a continuous observation of dining service in the main dining room, between 12/07/2025 11:37 AM and 12:43 PM, 3 staff members passed drinks to residents seated in the dining room and then left the room. 14 residents were present in the dining room. On 12/07/2025 11:52 AM Resident 1 began yelling asking for her lunch and requesting more to drink.On 12/07/2025 12:03 PM Resident 3 began yelling, calling for staff to wipe Resident 36's face. No staff were in the room to respond.On 12/07/2025 12:07 PM Resident 1 yelled several times requesting her lunch and then requesting to return to her room, indicating she was bored.On 12/07/2025 12:08 PM, Resident 3 responded to Resident 1 verbally, indicating she should just deal with it because all of the staff had left and no one was there.On 12/07/2025 12:09 PM Resident 31 verbalized concern of not knowing whether or not they would be able to eat. She indicated no staff was there and she wondered if any cooks had come to work that day.On 12/07/2025 12:10 PM Certified Nurse Aide (CNA) 14 came into the dining room and began pulling trays from a meal tray cart. Resident 3 yelled at CNA 14 to get a dishrag and wash Resident 36's face.On 12/07/2025 12:11 PM CNA 14 served 4 trays in the dining room. None of the trays were served to the same table. A tray was served to Resident 1 who was seated with one other resident. Another tray was served to a resident seated with Resident 49.On 12/07/2025 12:16 PM CNA 14 pushed the meal tray cart out of the dining room, No other staff were in the dining room. Resident 49 verbalized concern due to not receiving food and the cart being taken out of the room.On 12/07/2025 12:18 PM Resident 1 yelled about being cold, wanting medicine and wanting to leave the room.On 12/07/2025 12:19 PM another tray cart arrived in the dining room. Two residents seated with Resident 49 were served. Resident 49 verbalized concerns about not receiving his tray. He indicated he did not know if he would get any food that day. He indicated he was new so he didn't think the staff knew he needed food. Resident 3 yelled indicating Resident 49 just liked to complain. On 12/07/2025 12:24 PM another tray cart arrived in the dining room. Resident 1 yelled indicating she wanted to go to bed. CNA 6 began serving trays starting with a resident at a single table, then a table of 4 residents, none of which had been previously served.On 12/07/2025 12:30 PM Resident 49 indicated everyone was being served except for him.On 12/07/2025 12:33 PM Resident 49 was the last resident served in the dining room, 22 minutes after tablemates were served. In an interview, on 12/07/2025 12:35 PM, Certified Nurse Aide (CNA) 6 indicated dietary staff initially sent a cart of hall trays and placed it in the dining room. Staff removed 4 trays from the cart and served them to 4 residents in the dining room who tended to eat slower. She indicated she had not ever seen the four residents who received those trays seated together. She indicated the cart was then taken down the hall, and trays were passed to residents on the hall. She indicated additional hall (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trays came up in the next cart. She indicated the final cart sent up held the dining room trays and they were passed last. She indicated trays were frequently late and residents often voiced frustration with long waits.In an interview on 12/07/2025 12:38 PM, Qualified Medicine Aide (QMA) 3 indicated residents frequently complained about long waits for meals and frequently left the dining room before being served because they were upset about wait times.1) Resident 49's record was reviewed on 12/08/2025 11:45 AM. Diagnoses included cerebral infarction, dementia with agitation, and dysphagia.An admission screener form, dated 12/5/2025 12:55 PM indicated Resident 49 was alert and oriented to person, place, time and situation. No admission Minimum Data Set assessment was available for review at the time of facility exit. A current care plan titled At risk for decrease in activities of daily living indicated Resident 49 had a problem of a stroke with a goal date of 3/5/2026. Interventions included explaining all tasks and providing needed assistance with activities of daily living, including eating. A current care plan titled Nutrition indicated Resident 49 had a problem of being at risk for impaired nutrition with a goal date of 3/5/2026. Interventions included providing staff intervention and attention as needed. 2) Resident 3's record was reviewed on 12/11/2025 11:15 AM . Diagnoses included dysphagia following cerebral infarction, depression, and generalized anxiety disorder. A current quarterly Minimum Data Set assessment dated [DATE] indicated Resident 3 had a Basic Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS indicated Resident 3 received supervision or touching assistance with eating. 3) Resident 31's record was reviewed on 12/11/2025 11:32 AM. Diagnoses included Parkinson's disease with dyskinesia, generalized anxiety disorder and major depressive disorder. A current admission MDS assessment dated [DATE] indicated Resident 31 had a BIMS score of 14 (cognitively intact). The MDS indicated Resident 31 received supervision or touching assistance with eating. A current care plan titled Activities of Daily Living (ADL) indicated Resident 31 had a problem of risk for decline in ADL performance related to Parkinson's disease with a goal date of 3/4/2026. Interventions included providing assistance according to needs. A current care plan titled Nutrition indicated Resident 31 had a problem of risk for compromise in nutritional status with a goal date of 3/4/2026. Interventions included providing staff intervention and attention as needed. 4) Resident 1's record was reviewed on 12/11/2025 11:25 AM. Diagnoses included vascular dementia, severe protein-calorie malnutrition, phobic anxiety disorder and dysphagia. A current admission MDS dated [DATE] indicated Resident 1 had a BIMS score of 3 (severe cognitive impairment). The MDS indicated Resident 1 was dependent for eating activities. A current care plan titled Cognitive Deficit indicated Resident 1 had a problem of dementia with a goal date of 1/19/2026. Interventions included offering support and reassurance. 5) Resident 36's record was reviewed on 12/11/2025 10:51 AM. Diagnoses included Alzheimer's disease, dysphagia, adult failure to thrive, and anxiety disorder. A current quarterly MDS assessment dated [DATE] indicated Resident 36's BIMS score of 3 (severe cognitive impairment). The MDS indicated Resident 36 needed partial or moderate assistance with eating. In an interview, on 12/08/2025 2:23 PM, the Director of Nursing indicated 4 residents in the dining room were served earlier than others because they ate slowly. She indicated residents seated at the same table with those residents should be served within the next few minutes. She indicated residents should not have to wait long periods of time while others at their table had been served. A current policy titled Dignity, undated, provided by the Administrator on 12/9/2025 at 10:14 AM, indicated meal trays should be served by table so each person at a table does not experience long waits for meal service when others at their table had been served. 3.1-3(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review the facility failed to follow physician orders for 1 of 12 residents reviewed. (Resident 37) Findings include:A record review for Resident 37 began on 12/8/25 at 2:20 PM. Diagnoses included coronary artery disease, atrial fibrillation, chronic heart failure with mildly reduced ejection fraction measuring 41-49%, enlarged heart, high blood pressure, progressive neurological conditions, dementia, psychotic disorder, metabolic encephalopathy, and asthma. A review of Resident 37's current quarterly, MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 5 (cognitively impaired).A review of physician orders, dated 9/22/25 at 3:15 PM, indicated to give Bumex 2 mg, every 24 hours as needed for weight gain of 2-3 pounds, shortness of breath, and or edema. A review of physician orders, dated 9/23/25 at 7:15 AM, indicated daily weights were to be completed, recorded, and an additional Bumex administered if needed. A review of the Medication Administration Record (MAR), dated 10/1/25 to 10/31/25, indicated the following: On 10/2/25, a 3 pound weight gain had been documented. There was no documentation as needed Bumex was given.On 10/11/25, a 3 pound weight gain had been documented. There was no documentation as needed Bumex was given.On 10/31/25, documentation of a daily weight was not recorded. A review of the Medication Administration Record (MAR), dated 11/1/25 to 11/30/25, indicated the following:On 11/9/25, daily weight documentation was missing.On 11/10/25, a 4 pound weight gain had been documented. There was no documentation as needed Bumex was given, nor the physician was notified.On 11/28/25, a 2.5 pound weight gain was documented. There was no documentation as needed Bumex was given.A review of the Medication Administration Record (MAR), dated 12/1/25 to 12/11/25, indicated the following:On 12/2/25, daily weight documentation was missing.On 12/5/25, a 2 pound weight gain was documented. There was no documentation as needed Bumex was given.On 12/9/25, Daily weight documentation was missing. On 12/10, an increase in swelling (2+ edema) was documented. There was no documentation as needed Bumex was given.A review of the Treatment Administration Record (TAR), dated 12/1/25 to 12/08/25, indicated routine monitoring of edema had not been ordered.A review of Weekly Skin Assessments, from 9/2/25 to 12/9/25, indicated skin assessments did not prompt the assessment or record of edema. In an interview, on 12/9/25 at 10:15 AM, the Director of Nursing indicated facility staff had not been routinely documenting for edema prior to 12/9/25. She indicated there should not have been blank spaces for scheduled administration or tasks on the MAR.A current policy, titled Medication Administration Guidelines Inservice, undated, provided by the DON on 12/10/2025 at 10:40 AM, indicated staff should administer medications according to times of administration determined by the facility policy and or the physician. Staff are to sign the MAR immediately after administering medication, or document necessary administration information including as needed reason, refusal by resident, or hold medication per the facility policy. 3.1-37

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen orders were in place for 1 of 2 residents reviewed (Resident 47).Findings include:During an observation on 12/07/2025 10:25 AM, Resident 47 was lying in bed with a nasal cannula in place with an oxygen concentrator running at a rate of 4 liters per minute. In an interview on 12/07/2025 10:25 AM, Resident 47 indicated she had been using oxygen for a long time, for long term respiratory illnesses. Resident 47's record was reviewed on 12/7/2025 10:26 AM. Diagnoses included chronic respiratory failure with hypoxia, chronic diastolic heart failure, and chronic obstructive pulmonary disease. A review of Resident 47's current admission Minimum Data Set assessment (MDS), dated [DATE], included a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). Current physician orders did not include any orders for administration of oxygen. A progress note, dated 12/5/2025 at 1:19 AM, indicated Resident 47 received oxygen by nasal cannula per orders. A progress note, dated 12/6/2025 at 2:18 AM, indicated Resident 47 received oxygen by nasal cannula per orders. In an interview, on 12/07/2025 10:29 AM, Registered Nurse (RN) 4 indicated Resident 47's current physician's orders did not contain an order for administration of oxygen. He indicated there should have been a physician's order for oxygen. In an interview, on 12/08/2025 2:28 PM, the Director of Nursing (DON) indicated Resident 47 had recently returned to the facility from the hospital. She indicated she must have forgotten to enter the oxygen order in the medical record when she returned. She indicated nurses should check orders before administering oxygen and should contact the provider if an order was needed and not in place. A current policy titled Initiation of Oxygen, undated, provided by the DON on 12/082025 at 3:46 PM indicated nurses should verify physician's orders for oxygen prior to administration.3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were secured in the medication cart for 3 of 22 residents reviewed (Resident 53, Resident 40, and Resident 7).Findings include:In an observation on 12/10/2025 9:59 AM the medication cart, positioned next to the conference room, was unlocked with 3 cups of pills on top of the medication cart. Each cup contained several pills. No staff were present in the hallway or in the vicinity of the cart. Residents were present in the hallway and in the nearby dining room. In an interview, on 12/10/2025 at 10:01 AM, Registered Nurse (RN) 5 indicated she should not have left pills unattended on top of the cart. She indicated the cups of medication belonged to Resident 53, Resident 40, and Resident 7. She indicated she should prepare medicine for each resident individually, but had to prepare more than one at a time because at 10:00 AM the medications would be considered late. She indicated she felt rushed in the mornings because she was assigned to assist residents in the dining room, obtain blood sugar readings, administer insulin, administer an IV medication, assist with call lights and complete her medication pass by 10:00 AM.1) Resident 53's record was reviewed on 12/11/2025 1:46 PM. Diagnoses included syncope and collapse, hypertension, and chronic kidney disease, stage 3B.A progress note, dated 12/9/2025 at 11:19 PM, indicated Resident 53 had intact long and short term memory and had no signs of delirium. A progress note, dated 12/10/2025 6:21 PM, indicated Resident 53 was alert and oriented to person, place, and time. An admission Minimum Data Set assessment for Resident 53 was not completed at the time of facility exit. A review of current physician orders indicated Resident 53 had the following medication orders:Amlodipine Besylate 5mg, one tablet by mouth each morningAspirin enteric coated tablet 81 mg, one tablet by mouth each morningAtorvastatin Calcium 80 mg, one tablet by mouth each morningAzithromycin 250 mg, one tablet by mouth each morningBupropion HCl ER 300 mg, one table by mouth each morningFluoxetine HCl 60 mg, one tablet by mouth each morningMemantine 5 mg, one tablet by mouth each morningTamsulosin HCl 0.4 mg one capsule by mouth each morningColace 100 mg one capsule by mouth each morningDepakote delayed release 500 mg, one capsule by mouth each morningMucinex DM 500 mg 30-600mg, one tablet by mouth two times daily (morning and bedtime) 2) Resident 40's record was reviewed on 12/11/2025 1:54 PM. Diagnoses included diabetes type 2 and paroxysmal atrial fibrillation. A review of Resident 40's current admission Minimum Data Set assessment (MDS), dated [DATE], indicated Resident 40 had a Basic Interview for Mental Status (BIMS) score of 14 (cognitively intact). A review of current physician orders indicated Resident 40's current medication orders included:Finasteride 5 mg one tablet by mouth each morningFurosemide 40 mg one tablet by mouth each morningJardiance 25 mg one tablet by mouth each morningLisinopril 20 mg two tablets by mouth each morningMultivitamin one tablet by mouth each morningTamsulosin HCl 0.4 mg one capsule by mouth each morning3) Resident 7's record was reviewed on 12/11/2025 1:34 PM. Diagnoses included Alzheimer's disease and Bipolar disorder. Resident 7's current Annual MDS assessment, dated 9/23/2025, indicated Resident 40 had a BIMS score of 14 (cognitively intact). A review of current physician orders indicated Resident 7's current medication orders included:Amlodipine 10 mg, one tablet by mouth each morningCalcium with Vitamin D 500/400 mg-units, one tablet by mouth each morningGemtesa 75 mg, one tablet by mouth each morningLasix 20 mg, one tablet by mouth each morningQuetiapine Fumarate 50 mg, one tablet by mouth each morningSodium Chloride 1 GM, two tablets by mouth each morningSpironolactone 25 mg, one-half tablet by mouth each morningTylenol extra strength 500 mg, one tablet by mouth each morningBuspirone HCl 7.5 mg, one tablet by mouth each morningCarvedilol 12.5 mg, one (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet by mouth each morningD-Mannose, one capsule by mouth each morningDocusate sodium 100mg, one capsule by mouth twice daily (morning and bedtime)Memantine 5 mg, one capsule by mouth twice daily (morning and bedtime)Metformin 500mg, one tablet by mouth twice daily (morning and bedtime)Benztropine Mesylate 1 mg, one tablet by mouth three times daily (morning, midday, and bedtime)Depakote 500mg, one tablet by mouth each morningSimethicone 125 mg, one tablet by mouth three times daily (morning, midday, and bedtime)In an interview, on 12/10/2025 10:25 AM, the Director of Nursing (DON) indicated staff should work together to monitor the dining room. She indicated managers were available to go in and help. She indicated medications should be secured in the medicine cart when not directly attended to.A current undated policy, titled Medication Storage in the Facility, provided by the DON on 12/10/2025 at 11:25 AM, indicated medications should be stored securely and medication carts should be locked when not attended by authorized personnel.A current policy, titled Medication Administration Guidelines Inservice, undated, provided by the DON on 12/10/2025 at 10:40 AM, indicated staff should always ensure medicine carts are locked when they were away from the cart. The policy indicated no medications should be left on top of carts accessible to residents.3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to maintain safe food distribution, the storage, monitoring, and sanitation of tableware for 45 of 45 residents residing in the facility who eat meals prepared in the kitchen. Findings include:During an observation, on 12/7/2025 at 9:45 AM, the dishwasher rinse cycle, the thermometer indicated the temperature was 173 degrees Fahrenheit (F). The Dietary Manager was notified, and the dishes were run through the dishwashing cycle a second time with a rinse temperature of 172 degrees F, and 175 degrees F for a third cycle. The Dietary Manager indicated staff would use the three-sink sanitizer until the dishwasher was fixed.On 12/7/2025 at 10:02 AM, Dietary Aid 12 picked up a bowl off the floor, placed it in the dirty dishes area, then touched sanitized dishes without hand hygiene.During a continuous observation, on 12/7/2025 at 11:56 AM-12:15 PM, Dietary Aid 12 leaned her forearms on the clean work surface where meal trays were placed and assembled for meals. After Dietary Aid 12 stood up, she rested her bent elbow on the clean stack of trays. Water droplets of varying sizes were observed between 4 clean and stacked trays. The wet trays were then used for the flatware, dinner plate warmer, paper meal ticket, and a dessert plate. Stacked lids, too many to count, used for covering the meal plate, had moisture, and dripped liquid onto the prepared plates.An interview, on 12/7/25 at 12:09 PM, the Dietary Manager indicated trays and lids should be dry.A review of the Dishwasher Temperature Logs, dated December 2025, indicated temperatures were below the required temperature for sanitizing on 12/5/25 during the evening shift. A note, in the margin of the log, indicated dishes were to be sanitized using the 3-part sink method until the dishwasher was fixed.In an interview, on 12/9/25 at 11:22 AM, the Dietary Manager indicated she knew the dishwasher was failing to meet sanitizing temperature on Friday, 12/5/25. She indicated she had emailed the Regional Dietary Supervisor at 3:04 PM on 12/5/25, she indicated the dishwasher had not reached the minimum temperature of 180 degrees F since that time. The Dietary Manager indicated a maintenance staff member had been able to run the dishwasher several times, and it eventually reached 183. The Dietary Manager indicated she noticed the dishwasher failing to meet temperature requirements on Saturday,12/8/25 during the morning shift. Staff began to use the sanitizer sink method on 12/8/25 until the dishwasher returned to the required temperature. The sink method was stopped then. The 3-sink method includes submerging all items for 60 seconds, at minimum. The Dietary Manager indicated she did not have computer access to submit a work order to maintenance.In an interview, on 12/11/25 at 2:19 PM, the Administrator indicated all residents eat meals prepared in the kitchen.A current policy, undated, indicated food service employees were required to wash hands and exposed areas of their arms with soap and water upon entering the kitchen, before engaging in food preparation, after touching anything unsanitary, after touching bare human body parts other than hands and washed arms.A current policy, undated, indicated the dishwasher machine temperature was required to reach 180 degrees F during the final rinse. If the temperature were to read incorrectly, staff were to notify the Maintenance Department. If the dishwasher machine was not repaired by the next meal, disposable plates with plastic utensils may be used, or the dishes may be washed in the 3-sink method and allowed to air dry before being moved to storage.3.1-21(i) (3)