

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Waters of Hobart Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37th Ave Hobart, IN 46342	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>3. During random observations on 6/9/25 at 9:10 a.m., 6/10/25 at 10:10 a.m., and 6/11/25 at 9:10 a.m., tubes of clotrimazole and betamethasone diphenhydramine (a topical antifungal) and hydrogel (an advanced topical wound treatment) were observed on Resident 32's nightstand. At that time, the resident indicated staff left the topical medications in the room for when they provided wound care to her and Resident 36, who shared the room.</p> <p>The record for Resident 32 was reviewed on 6/17/25 at 10:30 a.m. Diagnoses included, but were not limited to, morbid obesity, chronic kidney disease, and difficulty walking.</p> <p>The 5/28/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required maximal assistance with activities of daily living (ADLs) and transfers.</p> <p>A Physician's Order, dated 4/15/25, indicated to cleanse the left plantar foot with wound cleanser, mix collagen particles and hyrogel to form a paste, fill wound bed with paste, cover with an ABD dressing, and wrap with rolled gauze every evening shift and PRN (as needed).</p> <p>During an interview on 6/11/25 at 4:21 p.m., the Director of Nursing was informed of the treatment medications left at the bedside and offered no further information.</p> <p>Based on observation and interview, the facility failed to ensure medications were properly labeled and stored for 2 of 3 medication carts observed and random room observations. (East medication cart and Northwest medication cart, Residents 48, 10, 21 & 32)</p> <p>Findings include:</p> <p>1. On 6/9/25 at 9:39 a.m., the East Medication Cart was observed with LPN 1. The following medications were not labeled or stored appropriately:</p> <p>a. There were 2 loose pills inside a medication cup in the top drawer.</p> <p>b. There was 1 loose pill inside a medication cup in the sixth drawer.</p> <p>During an interview at the time, LPN 1 indicated the resident had refused the pills in the top drawer and she needed a second nurse to waste the medication. She denied either pill was a narcotic. The single loose pill in a medication cup found in drawer six was not given by the night nurse. LPN 1 and RN 1 indicated they were told in shift report the medication, which was an antibiotic, needed to</p> <p>(continued on next page)</p>

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>be wasted.</p> <p>2. On 6/9/25 at 11:22 a.m., the Northwest Medication Cart was observed with QMA 1. The following medications were not labeled or stored appropriately:</p> <p>a. There was an insulin pen in the top drawer that was labeled with Resident 48's first name only. There were no administration instructions.</p> <p>b. There was a second insulin pen labeled with Resident 10's first name and last initial. There were no administration instructions.</p> <p>During an interview at the time, QMA 1 indicated she would have new labels put on the insulin pens.</p> <p>c. There was a probiotic bottle in the third drawer that was labeled with Resident 21's first and last initial. There were no administration instructions.</p> <p>During an interview at the time, QMA 1 indicated the medication was brought in by Resident 21, and she thought it was okay because the bottle had administration instructions.</p> <p>During an interview on 6/10/25 at 4:10 p.m., the Director of Nursing indicated the medication had already been corrected with new labels. There was no additional information provided.</p> <p>3.1-25(j)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to the cleaning of a shared glucometer before and after use for 1 of 1 glucometer (machine used to test blood sugar levels) test observed. (Resident 34)</p> <p>Finding includes:</p> <p>On 6/9/25 at 11:43 p.m., LPN 2 indicated she was going to check Resident 34's blood sugar level. The LPN walked in with the glucometer and indicated she had already cleaned the monitor, but she would clean it again. She grabbed a bottle of germicidal wipes and donned a new pair of gloves, she grabbed a couple of pieces of dry tissue and placed it on the bedside table. She then used the germicidal wipe to clean the glucometer. After cleaning the monitor she immediately wiped it dry with the dry tissue. Once the glucometer was dry, LPN 2 proceeded to obtain the resident's blood sugar. When the blood sugar test was completed, she walked the glucometer back to the medication cart and proceeded to clean the glucometer with a germicidal wipe. She again, immediately dried off the glucometer with a dry tissue. The glucometer was then placed back in the medication cart.</p> <p>During an interview on 6/9/25 at 12:01 p.m., LPN 2 indicated she cleaned the glucometer with the purple wipes (germicidal wipes) and then dried it off and wrapped it in a tissue. She indicated she did not know of any other way to clean the glucometer.</p> <p>During an interview on 6/10/25 at 11:46 a.m. with the Infection Preventionist (IP) and the Director of Nursing, the IP indicated she would expect staff to wipe down a glucometer with an appropriate germicidal wipe and wrap the germicidal wipe around the glucometer for 2-3 minutes. That was how she had educated the staff to clean the glucometer. The Director of Nursing (DON) indicated she would expect staff to follow manufacturer guidelines.</p> <p>A facility policy titled, Disinfecting Glucose Meters and received as current from the facility, indicated, .Contact time, also known as dwell/contact time is the amount of time an EPA registered disinfecting product needs to be present on a surface to be effective against microorganisms listed on it's label. Contact times usually fall between 30 seconds and 10 minutes .5. Use disinfected wipe per manufactures guidelines. Ensure all surfaces are wet and contact/dwell time is followed .</p> <p>The manufacturer guidelines for Sani Wipes indicated to disinfect and deodorize nonporous surfaces, .Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for 2 minutes. Let air dry .</p> <p>3.1-18(b)</p>		