STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Sullivan Nursing Facility, The	505 W Wolfe St Sullivan, IN 47882

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interview, the facility failed to control a gnat infestation of multiple areas throughout the facility for 4 of 4 residents reviewed for environment (Residents E, G, H, and J). This deficient practice had the potential to affect 48 of 48 residents who resided in the facility. Findings include:During resident interviews, the following was indicated:On 12/4/25 at 11:16 a.m., Resident E indicated his room was full of gnats in September and October. They had since disappeared. They were so bad in the dining room, you had to cover your beverage or there would be gnats floating in it. One day, he counted 10 in his coffee that he had forgotten to cover. During the interview, Resident E pointed to a bug trap tube hanging from his fire alarm that had a sticky surface. The trap was covered in dead gnats. He indicated he knew he was not supposed to have it in his room as staff had told him the Administrator said he could not have one, but he was so tired of dealing with the infestation in his room. On 12/5/25 at 10:56 a.m., Resident G indicated the gnats were so horrible and would crawl down his straw into his beverage. During one meal, he thought he had put pepper on his food only to realize it was gnats on his food. This went on for weeks and weeks. On 12/5/25 at 11:09 a.m., Resident H indicated the gnats were terrible in her room. She would cover her face at night with a tissue. She felt like it went on for about three months. On 12/5/25 at 10:15 a.m., Resident J indicated she had a lot of gnats in her room. She indicated they would fly out from under a cloth she used to cover her frequently used items on her overbed table. It was annoying. She developed maggots between her toes, and she believes it was from the insects in her room. A Skin Integrity Issue report, dated 10/31/25 at 8:00 a.m., provided by the Director of Nursing (DON) on 12/4/25 at 2:28 p.m., indicated Resident J was observed to have larvae in between her toes. The resident's feet were cleansed, and the resident bathed. No injuries had been observed at the time of incident. Predisposing Physiological Factors were indicated as prefers to be independent and declines assistance, incontinent, and fragile/sensitive skin. Predisposing Situation Factors were indicated as improper footwear, resistive to care, and non-compliant with safety instructions.During staff interviews, the following was indicated:On 12/4/25 at 2:08 p.m., CNA 2 indicated the facility was full of gnats starting in September through mid-October. The dining room was particularly bad. This issue with the gnats had been reported many times to administration.On 12/4/25 at 2:11 p.m., CNA 3 indicated there had been gnats everywhere and she would find them in her beverages. She felt the facility was not treating them aggressively enough and that was why they got so bad.On 12/4/25 at 2:35 p.m., CNA 4 indicated the gnats would fly straight into the residents' food and beverages. The staff had offered to get hanging traps and such, but were told the Administrator had said they could not do that. She did not feel like the issue was addressed timely or appropriately.On 12/4/25 at 10:35 p.m., CNA 6 indicated the gnats were a bad issue. She realized the facility did have a pest company spray for the gnats, but by that time they were very bad already. It would be better temporarily but quickly return to an (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infestation. She felt the facility failed to treat for them until they got really bad.On 12/4/25 at 10:42 p.m., CNA 7 indicated the gnats were an infestation. The pest control company that came in to treat for them had not seemed to help the situation at all. She felt the facility should have done something more to control them. On 12/4/25 at 10:51 p.m., LPN 8 indicated the gnats were horrible for a while and would get into residents' food when the covers were removed. They were everywhere.resident rooms, the nurses' stations, and the dining room. She felt the facility just ignored them for about a month until they got so bad. During an interview on 12/5/25 at 12:03 p.m. the Administrator indicated she had fired the Maintenance Director and the Assistant Maintenance Director, around 10/13/25, due to refusing to go into the crawl space with the Regional Consultant. The Regional Consultant had come into the facility to oversee the needs of the facility. She did not recall telling anyone that they could not have pest control devices in their rooms. During the infestation of gnats, she had not spoken to any of the residents regarding the gnats and what effect they were having on their day-to-day. She had not talked to staff regarding the gnat issue, but had received information from the department heads. She had called the pest company to complete two additional visits to address the gnats, outside of their regular monthly service. They had told her they would put foam in the drains, but other than that, there was not much else they could do. She had not considered reaching out to another provider for a second opinion and did not recall reporting the gnat infestation to the Director of Operations of the company. She had seen a few gnats in her office, but was not aware they had gotten so bad in the facility.A current facility policy, dated 2024, titled, Pest Control Policy, provided by the Administrator on 12/4/25 at 1:00 p.m., included the following: Purpose The purpose of this policy is to ensure a pest-free environment within out facilities by outlining procedures for the prevention, monitoring, and control of pest infestations. Responsibilities.Pest Control Provider: Conduct regular inspections, apply pest control measures, and provide detailed reports on pest activity and treatments.Monitoring: 1. Regular Inspections .Use pest monitoring devices, such as traps, to detect early signs of infestation .This citation relates to Intakes 2648148 and 2665791.3.1-19(f)(4)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility had failed to ensure enough nursing staff to provide resident care while covering laundry services since the end of October. This deficient practice had the potential to affect 48 of 48 residents who resided in the facility. Findings include:During an interview on 12/4/25 at 2:30 p.m., CNA 4 indicated she sometimes worked in laundry during her shift on the floor. She tried her best to not let it affect resident care and felt the nursing staff had stepped up to answer call lights when able. During an interview on 12/4/25 at 10:35 p.m., CNA 6 indicated she did laundry during her shift and had had to work much harder. The nursing staff had had to answer more call lights which was probably affecting charting and medication administration. She felt call light response times were being affected on the rehab/west hall. During an interview on 12/4/25 at 10:42 p.m., CNA 7 indicated she had done laundry during her shift. She had to leave the floor from time to time to complete loads of laundry. It had been a definite strain on the nursing staff. The residents seemed to understand the situation and were hoping it was resolved soon. The residents had to wait longer than normal at times for call lights to be answered. She felt it was unsetting that the Administrator showed no appreciation or acknowledgement at how hard everyone had worked without laundry staff to keep residents cared for. They had not scheduled additional staff to help that she had seen. Two to three times a week there were only two aides, a nurse, and a QMA on night shift to care for residents in addition to doing laundry. During an interview on 12/4/25 at 10:51 p.m., LPN 8 indicated she had done laundry during her shift to help out. She felt call light response times had definitely been longer and meal tray delivery and pick-up had been affected. They had since come up with a way to get the trays delivered timely and assured the residents received a warm meal. During an interview on 12/5/25 at 10:00 a.m., the DON indicated the staff had been stepping up to cover laundry services. Some of the CNAs were scheduled specifically to work in laundry occasionally, but she realized that had not covered the needs. The staff had been stepping in when able. During an interview on 12/5/25 at 11:09 a.m., Resident H indicated she had not noticed an increase in call light response times, but felt the staff were a lot more stressed lately. During an interview on 12/4/25 at 12:05 p.m., the Administrator indicated the CNAs had picked up additional hours to work in laundry. The facility only had one housekeeper and she had not worked weekends, so there was no housekeeping staff on the weekends. During an interview on 12/5/25 at 12:03 p.m., the Administrator indicated she had fired the Housekeeping Supervisor around 10/13/25. They currently had one fulltime housekeeper/laundry person. She tried to jump in and help with laundry, but would get pulled away being an Administrator. She had not reached out to her Regional Director of Operations to see what options might be for laundry coverage. She had not considered an outside source to cover the vacancy. She had not spoken to residents or staff about possible effects the laundry staff shortage and the CNA's covering that position, had caused. She received feedback regarding effect on staff, as in has anybody been hired? but not specifics of the effect on resident care. She was aware of their challenges but had not known the staff had run out of linens on night shift causing them to have to do loads of laundry on evenings and nights. A Facility Assessment Tool, updated 9/17/25, provided by the Administrator on 12/4/25 at 12:30 p.m., included the following: .Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies Example 2. Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time .Other (e.g., department heads, nurse educator, quality assurance, ancillary staff in maintenance, housekeeping, dietary, laundry) .1 FTE [Full Time Equivalent] Housekeeping Supervisor; 3 FTE Housekeepers/Laundry. This citation (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	relates to Intakes 2648148 and 2665791. 3.1-17(a)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, the Administrator failed to manage the facility in a manner that provided quality of life related to bug infestation, lack of available direct care staff, and a safe living condition of the facility environment. This deficient practice had the potential to affect 48 of 48 residents who resided in the facility. Findings include:Confidential interviews were conducted during the course of the survey, and indicated the Administrator never came on the floor to speak with staff or the residents. They felt she did not know the residents or staff at all and had shown a total lack of caring for the challenges being faced in the facility. The moral in the facility had suffered under the current Administrator. The added pressures placed on staff due to vacancies and the gnat infestation had been basically ignored. She had turned a blind eye to the issues facing the facility with the pests and lack of laundry staffing. During an interview on 12/4/25 at 11:16 a.m., Resident E indicated he had recently cut his arm on the door frame leading to his bathroom. During an observation at the time of the interview, the door frame to the bathroom was observed to have a trim piece that had been cut about 1/2 way up the frame, and a plastic sheeting had been placed at the bottom where the wood was missing. There was visible blood on the door frame where the resident had brushed up against it and cut his left upper arm. The resident indicated the Director of Nursing (DON), the Administrator and an outside audit group had come into his room and observed the door jam. The facility had been without a Maintenance Director for about a month and a half at that time, and the Administrator indicated they had hired a new Maintenance Director. She indicated to him not to overwhelm him and that he would fix the door frame when he was able. He indicated the Administrator had also fired housekeeping about a month ago and the CNAs had been doing the facilities laundry. They only had one girl who did the cleaning. He understood that the facility would run out of incontinent bed pads frequently causing the night nursing staff to have to do laundry. Resident E indicated his room had been full of gnats in September and October. They had since disappeared. They were so bad in the dining room, you had to cover your beverage or there would be gnats floating in it. One day, he counted 10 in his coffee that he had forgotten to cover. During the interview, Resident E pointed to a bug trap tube hanging from his fire alarm that had a sticky surface. The trap was covered in dead gnats. He indicated he knew he was not supposed to have it in his room as staff had told him the Administrator said he could not have one, but he was so tired of dealing with the infestation in his room. On 12/4/25 at 2:08 p.m., CNA 2 indicated the facility was full of gnats starting in September through mid-October. The dining room was particularly bad. This issue with the gnats had been reported many times to administration. On 12/4/25 at 2:35 p.m., CNA 4 indicated the gnats would fly straight into the residents' food and beverages. The staff had offered to get hanging traps but were told the Administrator had said they could not do that. She did not feel like the issue was addressed timely or appropriately. On 12/5/25 at 10:15 a.m., Resident J indicated she had a lot of gnats in her room. She indicated they would fly out from under a cloth she used to cover her frequently used items on her overbed table. It was annoying. She developed maggots between her toes, and she believes it was from the insects in her room. During an interview on 12/5/25 at 12:03 p.m., the Administrator indicated she had fired the former Maintenance Director, the Assistant Maintenance Director for refusing to go into a crawl space with the Regional Maintenance Consultant. This occurred around 10/13/25. The Regional Maintenance Consultant oversaw the maintenance needs of the facility after they had been let go. The Administrator indicated she had fired the Housekeeping manager in late October. They currently had one fulltime housekeeper/laundry staff person. She had tried to jump in and help with laundry, but would get pulled away being an Administrator. She had not reached (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	out to her Regional Director of Operations as to what her options might be for laundry coverage. She had not considered an outside source to cover the vacancy. She had not spoken to residents or staff about possible effects the laundry staff vacancy and the nursing staff covering that position. She got feedback regarding the effects on staff as in has anybody been hired? but not specifics of the effect on resident care. She was aware of their challenges but had not known the staff had run out of linens in the evenings and at night, causing them to have to do laundry on those shifts. She had been aware of the gnat issue. She does not recall telling anyone that they could not have pest control devices in their rooms. During the infestation of gnats, she had not spoken to any of the residents regarding the gnats and what effect it was having on their day-to-day. She had not talked to staff regarding the gnat issue but had received information from the department heads. She had called the pest company to complete two additional visits to address the gnats, outside of their regular monthly service. They had told her they would put foam in the drains, but other than that, there was not much else they could do. She had not considered reaching out to another provider for a second opinion and did not recall reporting the gnat infestation to the Director of Operations of the company. She had seen a few gnats in her office but was not aware they had gotten so bad in the facility. During an interview on 12/4/25 at 12:05 p.m., the Administrator indicated the CNAs had picked up additional hours to work in laundry. The facility only had one housekeeper and she had not worked weekends, so there was no housekeeping staff on the weekends. The facility also was without maintenance, but a new director had started about 10 days ago. The Regional Maintenance Director had trained him for about three days. The molding in Resident E room had not been fixed since he cut his arm. She was not sure when the new Maintenance Director would be able to fix the molding. Cross reference citations F0584 and F0725. This citation relates to Intakes 2648148 and 2665791. 3.1-13(a)(1)