STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wakarusa Skilled Nursing Facility, The	300 N Washington St Wakarusa, IN 46573

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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** 4. During an interview, on 3/10/2025 at 11:09 A.M., Resident 30 indicated she had very dry skin. A record review for Resident 30 was completed, on 3/13/2025 at 9:17 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and hemiplegia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/11/2025, indicated Resident 30 had moderate cognitive impairment and impaired range of motion to the upper and lower extremities on one side of her body. A Nurse Practitioner Skin and Wound Progress Note, dated 2/28/2025 at 9:26 A.M., indicated Resident 30's skin was dry, flaky and atrophied and was observed to have dry skin generalized to her entire body. An emollient skin application as needed for dry and/or atrophic skin was recommended by the nurse practitioner.However, there were no orders for an emollient to be provided to Resident 30 for her dry skin. A Care Plan, initiated 5/10/2025 and revised on 8/13/2024, indicated Resident 30 was at risk for additional areas of skin breakdown. The goal included, but was not limited to: Resident 30 would be provided with preventative measures to avoid skin breakdown. Interventions included, but were not limited to: monitor skin daily during care and notify the physician and family of any change in skin integrity. During an interview, on 3/14/2025 at 10:14 A.M., the Director of Nursing (DON), indicated Resident 30 should have had an order for an emollient if recommended by the nurse practitioner. During an interview, on 3/14/2025 at 11:19 A.M., the Regional Director of Clinical Services indicated the emollient for Resident 20 would have been ordered as needed if an issue of her skin arose. A policy was provided, on 3/14/2025 at 1:00 P.M., by the Director of Nursing. The policy titled, Guidelines for Preventative Skin Care, indicated, .Procedure: 1) Appropriate skin care is provided by staff each shift and/or as necessary 4. During an interview, on 3/10/2025 at 11:41 A.M., Resident 331 indicated the meals provided by the facility were high in carbohydrates and her blood sugars had been running high since her admission to the facility. A record review for Resident 331 was completed on 3/12/2025 at 10:03 A.M. Diagnoses included, but were not limited to: pathological fracture of left femur, malignant neoplasm of liver and lower lobe (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of left bronchus, secondary malignant neoplasm of bone and diabetes mellitus type 2. Resident 331 admitted to the facility on [DATE]. The admission MDS assessment had not yet been completed and was still in progress. Hospital discharge instructions, dated [DATE], indicated the following order: Insulin Lispro 100 units per milliliter Solution Sliding Scale subcutaneously as ordered as needed for serum glucose, see parameters: 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-400 give 9 units; Above 400 give 10 units. A Physician's Order, dated 3/7/2025 and discontinued 3/7/2025 by a pharmacy interchange order, indicated the following order was to be implemented for the interchange: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	361-400 give 9 units; Above 400 give 10 units. The Physician's Orders for Resident 331, from the pharmacy interchange order, was dated 3/10/2025 and indicated the following: Insulin Lispro 100 units per milliliter Solution inject as per sliding scale subcutaneously four times a day for diabetes: if 140-160 give 1 unit; 161-180 give 2 units; 181-200 give 3 units; 201-220 give 4 units; 221-240 give 5 units; 241-280 give 6 units; 281-320 give 7 units; 321-360 give 8 units; 361-399 give 9 units and notify MD if over 350; 400-500 give 10 units and notify MD. A review of the Medication administration record indicated Resident 331 received Lispro sliding scale insulin on the following dates between 3/7/2025 and 3/10/2025. -3/7/2025 at 4:30 P.M. -3/10/2025 at 7:30 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M. Resident 331 did not receive any sliding scale insulin on 3/8/2025 or on 3/9/2025. A Care Plan, initiated 3/10/2025, indicated Resident 331 had a diagnosis of diabetes mellitus type 2 with the risk of hypo/hyperglycemia. Interventions included, but were not limited to: administer medications and insulins per order. During an interview, on 3/14/2025 at 11:28 A.M., the Regional Director of Clinical Services indicated the pharmacy had issued a therapeutic interchange of the sliding scale insulin on 3/7/2025 and the sliding scale insulin order was not signed by the nursing department and implemented until 3/10/2025. She indicated Resident 331 had missed two days of the sliding scale insulin ordered. On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, Guidelines for Physician Orders- Following Physician Orders, dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated : . It is the policy of the facility to follow the orders of the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician. At the time of admission the facility must have physician orders for the resident's immediate care . 4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received 3.1-37(a) 2. A record review was completed for Resident 55 on 3/13/2025 at 11:32 A.M. Diagnoses included, but were not limited to: senile degeneration of the brain and dementia. A Quarterly MDS (Minimum Data Set) assessment, dated 2/10/2025 indicated Resident 55's cognition was significantly impaired. A significant changed MDS was completed on 1/26/2025 indicating the resident was receiving hospice services. A Physician's Order, dated 1/15/2025 indicated hospice was to evaluate and treat the resident per family request. A Physician's Order, dated 1/17/2025 indicated Resident 55 was accepted to (name of hospice) and was a DNR (do not resuscitate). A current Care Plan, revised on 1/20/2025 indicated Resident 55 elected hospice services and was to be followed by hospice care (name of hospice). Interventions included, but were not limited to: Staff nurses will contact hospice with information that affects resident care. On 3/13/2025 at 1:35 P.M., a review of Resident 55's hospice book was completed. The resident's hospice book lacked documentation of the resident's medications, physician's orders, a signed DNR and any communication between the facility and (name of hospice). During an interview on 3/13/2025 at 1:38 P.M., the DON indicated the resident's hospice book should have had a copy of the resident's signed DNR, current orders, medications and any communication between the facility and (name of hospice). On 3/13/2025 at 2:16 P.M., the DON provided a policy titled, Guidelines for Palliative Care- Hospice Care, dated 10/9/2024 and indicated it was the policy currently being used by the facility. The policy indicated, : What must a LTC facility do as their part for partnering with the hospice provider? D. A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the residents are addressed and met 24 hours per day 3. A record review was completed for Resident 6 on 3/11/2025 at 1:09 P.M. Diagnoses included, but were not limited to: atrial fibrillation, coronary atherosclerosis and hypertension. A Physician's Order indicated Resident 6 was to receive Triamterene and Hydrochlorothiazide 37.5-25 mg (milligram) tablet by mouth, one time a day for hypertension. The medication was to be held if the resident's systolic blood pressure was below 110 mmHg (millimeters per mercury). A review of Resident 6's MAR (medication administration record) indicated the Triamterene and Hydrochlorothiazide 37.5-25 mg tablet was documented as given on the following dates, when the resident's blood pressure was outside the recommended parameter: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 11/21/2024 the resident's blood pressure was 100/50 mmHg. - on 11/22/2024 the resident's blood pressure was 102/54 mmHg. - on 12/11/2024 the resident's blood pressure was 97/53 mmHg. - on 12/22/2024 the resident's blood pressure was 108/62 mmHg. - on 1/4/2025 the resident's blood pressure was 102/60 mmHg. - on 1/21/2025 the resident's blood pressure was 88/58 mmHg. - on 2/1/2025 the resident's blood pressure was 91/52 mmHg. - on 2/16/2025 the resident's blood pressure was 105/58 mmHg. During an interview on 3/12/2025 at 1:53 P.M., the DON indicated the resident's medication should have been held on the days her blood pressure was outside the recommended parameters. On 3/12/2025 at 1:09 P.M., the DON provided a policy titled, Guidelines for Physician Orders- Following Physician Orders, dated 6/18/2023 and indicated it was the policy currently being used by the facility. The policy indicated, .4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received Based on observation, interview and record review the facility failed to follow a Physicians order to hold a hypotensive medication (Resident 24), failed to keep a complete hospice binder (Resident 55), failed to follow physician's orders regarding hypertensive medication (Resident 6), failed to provide recommended emollient for skin (Resident 39), and failed to provide sliding scale insulin for 2 day for a resident with diabetes mellitus (Resident 331). Finding includes: 1. The record for Resident 24 was reviewed on 3/12/2025 at 9:43 A.M. Diagnoses included but were not limited to: pulmonary hypertension, orthostatic hypotension, obesity, congestive heart failure, and anxiety. Physician Orders included but were not limited to: carvedilol 3.125 milligrams (mg) daily, torsemide 10 mg daily, and midodrine 5 mg three times a day, hold for systolic blood pressure (SBP) greater than 120. The Medication Administration Record MAR for January 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 42 times. The MAR for February 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 28 times. The MAR for March 2025 indicated that Resident 24 had a SBP greater than 120 and the medication midodrine was administered 7 times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 2:34 P.M., Regional Nurse indicated on the days with SBP greater than 120, the midodrine should not have been administered. During an interview on 3/13/2025 at 10:41 A.M., LPN 7 indicated if Resident 24's SBP was greater than 120 the facility staff should not have administered the medication.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record review and interview, the facility failed to provide urostomy care and required urostomy supplies for 1 of 3 residents reviewed for urinary devices. (Resident B) Finding includes: A record review for Resident B was completed on 3/11/2025 at 10:19 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage 2, anal fissure, other artificial openings of urinary tract and dementia. A Medicare 5-day Minimum Data Set (MDS) assessment, dated 2/15/2025, indicated Resident B's cognitive status was not able to be assessed and he had a urostomy. The medical record did not have any physician orders related to a urostomy or the care of the urostomy. An Internal Medicine History and Physical, provided by the hospital from the 2/9/2025 admission, indicated Resident B had a past medical history of a malignant neoplasm of the posterior wall of the urinary bladder and a cystectomy that occurred on 6/3/2019. An Admission/re-admission Screener Assessment, on 2/12/2025 at 5:00 P.M., indicated Resident B was continent of his bladder. A Bowel and Bladder Incontinence Screener Assessment, on 2/13/2025 at 9:06 P.M., indicated Resident B voided appropriately without incontinence. Daily Skilled Nursing Notes, from 2/14/2025 through 2/16/2025, indicated the following urinary descriptions: -2/14/2025 at 2:42 A.M., Urinary: Continent. -2/14/2025 at 10:18 A.M., Urinary: Continent/Incontinent. -2/16/2025 at 5:23 A.M., Urinary: Continent -2/16/2025 at 11:27 A.M., Urinary: Continent, Resident has a urostomy. A document titled, I Would Like to Know , indicated a concern from family regarding, .Urostomy bag leaked and he sat in urine all night, Facility should have the necessary supplies on hand for the resident. His significant other is bringing in supplies A document titled, Internal review of 'I Would Like to Know ' Form [QA Tool], dated 2/14/2025, indicated the following: urostomy site and bag examined and a small amount of urine was on the chux pad (disposable, absorbent bed pad) under Resident B's back. A new bag and wafer were replaced by the Assistant Director of Nursing on 2/14/2025. The Marketing Director was to request urostomy supplies to be sent by the hospital for urostomy maintenance. When Resident B arrived, no urostomy supplies were sent to the facility. The family provided the needed urostomy supplies the following day. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Customer Service Progress Note, on 2/14/2025 at 1:00 P.M., indicated a discussion of urostomy supplies was conducted with Resident B and his wife. The information from the urostomy supplies (bags and wafers) the wife provided was taken so the facility could order the supplies needed to take care of the urostomy. Resident B requested a larger urinary drainage bag for overnight use. Resident B's wife brought in a larger drainage bag and a small tubing adaptor. The nursing staff reinforced the urostomy wafer and there had been no more leaking reported. A Nursing Progress Note, on 2/14/2025 at 10:34 P.M., indicated Resident B's wife had reported a leak was present with Resident B's urostomy. An assessment was completed and Resident B was dry with no leak noted. Resident B's daughter was at the bedside and requested the urostomy bag be changed. The nurse indicated dinner was being served soon and the nurse would change the urostomy bag after dinner so Resident B could lay down. Resident B's wife was statisfied with the plan and reassured resident B's daughter. The urostomy bag was changed after dinner. A Social Service Note, on 2/15/2025 at 1:00 P.M., indicated the Social Service Director called the family to discuss the urostomy. The Social Service Director had been in the building and had discovered the urostomy had been replaced and was working properly. A General Progress Note, on 2/16/2025 at 10:00 A.M., indicated Resident B's daughter stated, We are taking him home. A Care Plan, initiated on 2/14/2025 and revised on 2/14/2025, indicated Resident B had urinary incontinence related to physically or mentally unawareness of the need to void. The care plan, nor any other care plans, addressed Resident B's urostomy. During an interview, on 03/14/2025 at 10:02 A.M., the Director of Nursing indicated Resident B was admitted to the facility on a Thursday (2/13/2025). She indicated the Marketing Director was to request that the hospital send urostomy supplies or was to arrange for the family to bring supplies until the facility could order the needed supplies for the urostomy. She indicated the supplies did not come from the hospital nor was the family made aware of the need to bring urostomy supplies. She indicated Resident B's family complained of Resident B lying in urine and that the CNA working had been reluctant to provide urostomy care per Resident B's complaints. She indicated the Assistant Director of Nursing had checked Resident B on Friday (2/14/2025) morning for leakage from the urostomy bag and had applied a new urostomy bag. The facility had also brought in an indwelling catheter bag to connect to the urostomy bag, so the urostomy bag did not need to be drained every two hours. A policy was provided, on 3/11/2025 at 1:48 P.M., by the Director of Nursing. The policy titled, Urostomy, indicated, .A urostomy is similar to a fecal ostomy, but it is an artificial opening for the urinary system and the passing of urine to the outside of the abdominal wall through an artificial created hole called a stoma .A urostomy patient has no voluntary control of urine, and a pouch system must be used and emptied regularly. Many patients empty their urostomy bag every 2 to 4 hours .the pouch should be emptied when it is 1/3 full. The pouch may also be attached to a drainage bag for overnight drainage This citation relates to complaint IN00453772. 3.1-47(a)(3)