STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00385701 and IN00396036. Survey dates: February 28 and March 1, 2023. Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 5 Medicaid: 20 Other: 12 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/6/23.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to ensure a medication self administration assessment was completed prior to leaving medications at the bedside for 1 of 1 random observations of medications. (Resident C)	F 0554	**Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this**	03/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jarrett Mitchell	Administrator	03/20/2023

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	Finding includes: On 2/28/23 at 9:33 a.m., Resident C was observed lying in his bed. There was a bottle of fluticasone (nasal spray) on his bedside table. The resident's record was reviewed on 2/28/23 at 10:03 a.m. Diagnoses included, but were not limited to, schizoaffective disorder and chronic obstructive pulmonary disease. A Physician's Order, dated 11/8/22, indicated fluticasone suspension 50 microgram, 1 spray in each nostril two times daily. There was no documentation a medication self administration assessment had been completed. There was no Physician's order to allow the resident to self-administer medications. Interview with the Assistant Director of Nursing on 2/28/23 at 10:15 a.m., indicated there was not medication self administration assessment and the medication should not have been left at bedside. This Federal tag relates to Complaint IN00385701. 3.1-11(a)		**statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 20, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 20, 2023.** **F 554 Self-Administration of Medications** ="" p="">"> · Resident C: A self-administration of medication assessment was completed on 3/2/2023, obtained physician order for self-administration of fluticasone suspension 50 microgram. Care plan was updated to reflect this change. · A sweep of resident rooms was conducted 3/2/2023 to ensure there were no additional medications at bedside unless the self-administer medications policy/procedure had been implemented. **All residents have the potential**	

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			to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. · On-going monitoring of items in resident rooms by all staff to make sure items are secured in resident locked cabinet if applicable or in the medication cart. · The DON/Designee educated nursing staff on 3/16/2023 on the completion the self-administration assessment if applicable before any resident self-administers medication, this includes leaving any medications at bedside. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · DON or designee will round at random checking resident's rooms for any medications that should be secured 5 days a week x 4 weeks, then weekly x 4 weeks, and then monthly x 4 months to monitor ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days. See attachment A.	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure Care Plan interventions were in place for a resident at risk for developing pressure ulcers and new pressure ulcers were assessed and treatment orders obtained for 2 of 3 residents reviewed for pressure ulcers. (Residents G and D) Findings include: 1. On 2/28/23 at 2:12 p.m., Resident G was observed lying in her bed. She was on a standard mattress. The resident's record was reviewed on 2/28/23 at 1:40 p.m. Diagnoses included, but were not limited to, hemiparesis and hemiplegia (one sided weakness and paralysis) following a cerebral vascular event and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 2/14/23, indicated the resident	F 0686	**Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 20, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of**	03/27/2023

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	needed total two person assistance for bed mobility and transfers, and had severe cognitive impairment. The current Skin Risk Care Plan indicated the resident was at risk for skin breakdown due to hemiparesis and requiring total assist for bed mobility. Interventions included a low air loss mattress. Weekly Wound Evaluations indicated on 1/17/23, a deep tissue injury (DTI) was noted to her left heel measuring 3 centimeters (cm) x 2 cm. On 2/7/23, an unstageable pressure area was noted on her coccyx measuring 4.5 cm x 3 cm. The resident continued to receive wound care to both areas. A General Note, dated 1/4/23, indicated the resident was receiving hospice services, but those services were scheduled to end on 1/6/23 due to the resident no longer met hospice criteria. Interview with the Director of Nursing (DON) on 3/1/23 at 9:25 a.m., indicated the resident had not had a low air loss mattress since hospice had ended, and the care plan had not been updated. She indicated she would look into getting the resident an air mattress as any resident with a stage 2 pressure ulcer or above should have an air mattress. 2. The closed record for Resident D was reviewed on 2/28/23 at 11:00 a.m. The resident was admitted on 10/25/22. Diagnoses included, but were not limited to, aftercare following joint replacement. The Admission MDS assessment, dated 11/1/22, indicated the resident was cognitively intact and required limited one person assist for bed mobility and transfers.		**Compliance and requests a desk review in lieu of a post survey review on or after March 20, 2023.** **F686 Treatment/Services to Prevent/Heal Pressure Ulcer** **It is the policy of this facility for residents who have skin break down are at risk for breakdown. Have the appropriate assessments, treatments, and care plan interventions in place.** · Resident G: Low air loss mattress put in place on 3/2/2023. Care plan updated and treatments orders clarified on 3/2/2023. · Resident D: No longer resides in facility. **While all residents have the potential to be affected by this alleged deficient practice, no negative outcomes were identified.** · DON/Designee identified All residents at risk for skin breakdown, audited their orders and care plans, and ensured that each one of the identified residents had appropriate individualized interventions in place by 3/2/2023 · DON/Designee educated nursing staff on 3/16/2023 on pressure ulcer prevention policy. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as	

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	The 10/25/22 Admission Assessment indicated there was red pressure area on buttock developing. Barrier cream was to be applied to the area every shift. There was no additional assessment of the pressure area. A New Wound Assessment, dated Monday 10/31/22, indicated the resident had new pressure areas to left buttock measuring 1 centimeter (cm) x 1.5 cm, open right upper buttock 2.5 cm x 1.5 cm and right buttock 1 cm x 1 cm. There was no assessment of the wound bed, surrounding skin, exudate, odor or pain. The assessment indicated the family and Nurse Practitioner had been notified. There was no new treatment order or indication what treatment had been provided to the new areas. A General Note, dated Tuesday 11/1/22 at 4:35 p.m., indicated the resident left the facility against medical advice. There was no documentation the wound nurse had assessed the pressure areas. The policy, "Wound (Pressure Injury) and Non-wound Assessment and Documentation", was provided by the DON as current on 3/1/23 at 11:10 a.m. The policy indicated, "...All wounds, as defined below, will be managed by the facility wound nurse...Assessment findings will be document on the 'Pressure injury assessment and non-pressure injury assessment' located in the EMR...." Interview with the DON on 3/1/23 at 9:40 a.m., indicated the protocol at that time was the wound nurse was to be notified and managed all new wounds. She was in the facility on Tuesday, Thursday, Saturday and Sunday. The resident had left the facility the day after the wounds were		indicated. · DON/Designee will audit 5 residents a week x 4wks, then 3 residents a week x 4 weeks, and then monthly x 4 months for placement of pressure prevention interventions. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days. See Attachment A.	

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	noted, and barrier cream remained the only treatment ordered. This Federal tag relates to Complaint IN00396036. 3.1-40(a)1 3.1-40(a)2			