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	02/07/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00424611. Complaint IN00424611 - Federal/state deficiencies related to the allegations are cited at F755 and F759. Unrelated deficiency is cited. Survey dates: February 6 and 7, 2024. Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 10 Medicaid: 28 Other: 8 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/8/24.	F 0000		
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kristina Herrera | Executive Director | 02/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure pharmacy services were provided for a resident, related to a scheduled pain medication not provided as ordered, for 1 of 3 residents reviewed for pharmacy services. (Resident C) Finding includes: The closed record for Resident C was reviewed on 2/6/24 at 9:28 a.m. Diagnoses included, but were	F 0755	F-755 Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of 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	02/22/2024

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	not limited to, breast cancer, liver and bile duct cancer, pleural effusions and depression. The resident was discharged from the facility on 12/18/23. The Quarterly Minimum Data Set assessment, dated 11/13/23, indicated the resident was cognitively intact. She required extensive assist of 2 staff for transfers and toileting, and extensive assist of 1 for bed mobility. A Physician's Order, dated 11/8/23, indicated to give Oxycodone/acetaminophen 5 milligrams (mg) /325 mg (an opioid pain analgesic) every evening for severe pain. The November 2023 Medication Administration Record (MAR) indicated, between 11/8/23 and 11/30/23, the medication was not given 22 times. The December 2023 MAR indicated, between 12/1/23 and 12/18/23, the medication was not given 16 times due to refusal or other, see administration notes. Administration Notes indicated the following: 11/8/23 - Not available 11/11/23 - Order clarification pending 11/12/23 - Pending order clarification 11/15/23 - Unavailable 12/3/23 - Spoke with NP (Nurse Practitioner) and no escript given to pharmacy until primary care service sees resident, as a temp script was already given in November... 12/5/23 - Need med 12/16/23 - Need a prescription per pharmacy. Doctor aware. 12/17/23 - No physician order in pharmacy, will not be dispensed until the medical team follows up.		compliance with State and Federal Laws. Facility's date of alleged compliance (February 22,2024) Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the intent of this facility to ensure pharmacy services were provided for a resident, related to a schedule pain medication. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident C no longer resides in the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with medication orders have the potential to be affected by this alleged deficiency. The DON/Designee completed an audit of ALL residents receiving pain medications for availability of medication. Any concerns were immediately addressed. This audit was completed on 02/15/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	During an interview with the Director of Nursing, on 2/7/24, she indicated there had been some difficulty with pharmacy and practitioners ordering medication, as the pharmacy would deny receiving orders, and practitioners claiming they sent escript in to the pharmacy. This citation relates to Complaint IN00424611. 3.1-25(a)		The DON/Designee in-serviced the nursing staff on (DATE) on the following. 1 Pharmacy Services. 2 Medication Administration 3 Documentation of refusal of medication. 4 EDK medications and access 5 Notification of physician and pharmacy for refills. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will audit 10 random residents weekly for availability of pain medications and administration of pain medication weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the	

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			QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 02/22/2024	
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 4 residents observed during medication pass. Four errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 14.8%. (Residents E and F) Findings include: 1. On 2/6/24 at 9:10 a.m., medication pass was observed with RN 1. LPN 1 was also present to observe. The RN prepared Resident E's medications. She placed 6 tablets in a packet and crushed them, then mixed with pudding in a plastic cup. There was one chewable vitamin in another cup. She administered the medications to the resident.	F 0759	F759 It is the intent of this facility for the residents to be free from medication errors. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident E and resident F had no negative outcome from this alleged deficient practice · Resident E and resident F will receive the correct medication dosage and route. On 02/07/2024 by LPN, both E and F were assess for negative outcomes related to this alleged deficient practice. No negative outcomes noted. Resident E Responsible party and Physician were notified on	02/22/2024

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	The resident's medications were reconciled on 2/7/24. The February 2024 Medication Administration Record (MAR) indicated the resident was also to receive the following medications in the morning: - Miralax 17 grams - Trelegy 200/ 62.5 mg inhaler - Voltaren 1% gel, 4 grams These medications had been signed out on the MAR, but had not been given during medication observation. 2. On 2/7/24 at 8:15 a.m., medication pass was observed with QMA 1. LPN 1 was also present to observe. The QMA prepared Resident F's medications. Included was clotrimazole cream 1% (an anti-fungal), which she dispensed into a plastic cup. She administered the medications to the resident. The resident indicated she did not want the cream. The resident's medications were reconciled on 2/7/24. The February 2024 MAR indicated the resident was to receive Voltaren 1% gel (an analgesic), not clotrimazole. The Voltaren had been signed out as refused. During an interview with LPN 1, on 2/7/24 at 10:30 a.m., she indicated the RN had only administered the oral medications to Resident E. She indicated she was not aware the QMA had prepared the incorrect cream for Resident F. This citation relates to Complaint IN00424611. 3.1-48(c)(2)		02/07/2024 of the alleged practice. RN1 no longer is employed by the facility. Resident F refused the medication. QMA 1 was educated on 02/07/2024 for medication administration and errors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with orders for medications have the potential to be affected by the same alleged deficient practice. Therefore, this plan f correction applies to all residents of the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced the ALL nursing staff by 02/20/2022on the following. 1 Medication Administration 2 Five Right of Medication Administration. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be	

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			put into place. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. 02/22/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and			

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	controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording			

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	incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure infection control measures were in place and implemented, related to lack of hand hygiene during medication pass and wound care, for two random observations for infection control. (QMA 1 and LPN 1) Findings include: 1. On 2/7/24 at 8:15 a.m., medication pass was observed with QMA 1. LPN 1 was present also to observe. The QMA prepared the medication for Resident E and administered it. She then returned to the medication cart, and began preparing medication for the next resident. She prepared Resident F's medication and gave it to him. The QMA did not perform hand hygiene between the two residents' medications. During an interview with the QMA after the observation, she indicated she did not complete hand hygiene between the two residents. 2. On 2/7/24 at 9:55 a.m., wound care was observed with LPN 1. LPN 1 positioned the resident on his side to change a dressing on his sacrum. She donned gloves and removed the old	F 0880	F-880 It is the intent of this facility for the residents to ensure that infection control measures are in place and implemented including handwashing to be complete during medication pass and wound care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident E and F was assessed by LPN on 02/07/2024 no negative outcome related to the alleged deficient practice. LPN 1 and QMA 1 were provided with education on handwashing and infection control by the Infection Control Nurse on 02/07/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resident that resides in the	02/22/2024

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	dressing. She then cleansed the area with wound wash, patted the area dry, and then applied a new dressing. She then assisted the resident to a comfortable position, gathered her supplies for disposal, and removed her gloves. During an interview with LPN 1 after the observation she, indicated she should have completed hand hygiene and changed gloves after removing the old dressing. 3.1-18(b)		facility have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced nursing staff on (DATE) on the following. 1 Handwashing 2 Infection Control Additionally, any staff member that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will complete a Medication Observation to include handwashing on 5 random nursing staff members once a week x 4 weeks, then 3 random staff members x 4 weeks, then 2 random staff members monthly x 4 months. These Observations will be conducted on random shift and hallways. The DON/Designee will complete a Dressing Change Observation to include handwashing on 5 random nursing staff members once a week x 4 weeks, then 3 random staff members x 4 weeks, then 2	

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			random staff members monthly x 4 months. These Observations will be conducted on random shift and hallways. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date the systemic changes for each deficient will be completed. Date of compliance 02/20/2024	