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	05/12/2023

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 a Recertification and State Licensure Survey. Survey dates: May 8, 9, 10, 11, and 12, 2023 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 40 SNF: 6 Total: 46 Census Payor Type: Medicare: 13 Medicaid: 24 Other: 9 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/15/23.	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 residents had Physician's Orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 21	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**	06/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jarrett Mitchell	Administrator	05/26/2023

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.

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	05/12/2023

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
	and 23) Findings include: 1. On 5/8/23 at 10:06 a.m., Resident 21 was observed in her room. There was a white pill in a medicine cup on her bedside table. The resident indicated that it was her Tylenol that she received this morning, but she did not need it a the time so she wanted to wait to take it at a later time when she had pain. Resident 21's record was reviewed on 5/9/23 at 1:23 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia without behavioral disturbance, and chronic pain. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/4/23, indicated Tylenol 8 hour arthritis pain tablet extended release 650 milligram (mg) two times a day. A Care Plan, dated 2/28/23, indicated the resident would like to administer and/or have medications in her room. Interventions included, but were not limited to, complete self-administration assessment initially and then quarterly or as needed to ensure storage safety and continued ability to self-administer. There were no orders for self-administration of Tylenol. There were no assessments completed for self-administration of medication for Tylenol.		**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 June 14th, 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 June 14th, 2023.** **F 554 Self-Administration of Medications** /p> · Resident 21 and Resident 23: A self-administration of medication assessment was completed on 5/13/2023, obtained physician order for self-administration of medications for both residents. Care plan was updated to reflect this change. · A sweep of resident rooms was conducted 5/13/2023 to ensure there were no additional medications at bedside unless the self-administer medications policy/procedure had been implemented. **All residents have the potential to be affected by this alleged**	

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	05/12/2023

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
	Interview with the Director of Nursing on 5/10/23 at 3:11 p.m., indicated the resident has tried to keep Tylenol at the bedside before when she was working the floor so she was aware of this behavior. The resident should have an assessment and a Physician's order to keep the Tylenol at the bedside. 2. On 5/8/23 at 11:00 a.m., Resident 23 was observed sitting on her bed with her eyes open. There was a bottle of eye drops sitting on the cabinet by the bed. Interview with Resident 23 on 5/9/23 at 12:52 a.m., indicated she administered her eye medication every night. Resident 23's record was reviewed on 5/10/23 at 8:56 a.m., Diagnoses included, but were not limited to, paranoid schizophrenia, schizoaffective disorder, bipolar type generalized anxiety disorder, and glaucoma. There was no documentation to indicate a self-medication administration assessment had been completed. There was no Physician's order to self-administer medications. Interview with the Nurse Consultant on 5/10/23 at 10:59 a.m., indicated she would look for the assessment, it might be a paper document. Interview with the Director of Nursing (DON) on 5/10/23 at 1:15 a.m., indicated she was not able to locate a self-administration assessment. A policy, titled "Self-Administration of Medications by Residents," received from the DON as current, indicated an Interdisciplinary		**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 5/13/2023 on the "Self-Administration of Medications by Residents", 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 10 resident's rooms for any medications that should be secured for 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. · Completed by 06/14/2023.	

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	05/12/2023

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
	team determines the resident's ability to self-administer medications by means of a skilled assessment. If bedside storage is to be used, the resident is asked to complete a bedside record indicating the administration of the medication. The medications provided to the resident for bedside storage are kept in the locked containers or locked drawer and a Physician's Order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the interdisciplinary team. The order is to be recorded on the medication administration record. 3.1-11(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent with Activities of Daily Living (ADLs) received the necessary services related to long and dirty fingernails for 1 of 3 residents reviewed for ADLs. (Resident 18) Finding includes: On 5/8/23 at 10:27 a.m., on 5/9/23 at 10:00 a.m., and 5/10/23 at 1:45 p.m., Resident 18 was observed in bed. At those times, her left hand was clenched in the shape of a fist and there was no anti-contracture device noted. Her fingernails were not visible. On 5/11/23 at 9:00 a.m., the Director of Nursing	F 0677	**F677 ADL Care Provided for Dependent Residents** It is the policy for this facility that all resident that need assistance with activities of daily living are done to maintain good nutrition, grooming, personal care, and hygiene. · Resident 18 nail care was administered on 5/11/23 and her care plan has been updated to reflect the need for daily assistance with ADL's. Additionally, a facility wide sweep of resident's nails were done and any concerns were addressed. **All residents have the potential**	06/14/2023

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	05/12/2023

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
	(DON) was asked to perform a skin assessment to the resident's left hand. At that time, the resident was observed sitting up in a broda chair in her room. CNA 1 was observed standing by the resident and had just finished morning care. The resident had a rolled wash cloth in her left hand and her fingernails were visible. The resident had very long and dirty nails observed to the left hand. LPN 2 walked into the room with a pair of fingernail clippers and indicated she was going to trim her nails. The record for Resident 18 was reviewed on 5/10/23 at 11:05 a.m. The resident was admitted to the facility on 4/12/23. Diagnoses included, but were not limited to, stroke, hemiplegia on the left side, vascular dementia, and contracture of the left knee and the left hand. The 4/19/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The resident was an extensive assist with a 2 person physical for ADLs and had a physical range of motion impairment to both the upper and lower extremities on one side. A Care Plan, dated 4/12/23, indicated the resident had a late loss in her ADL function due to a left hand contracture, left side hemiplegia, and dementia. Interview with the DON on 5/11/23 at 9:00 a.m., indicated her fingernails were very long and in need trimming. 3.1-38(a)(3)(E)		**to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** · The DON/Designee educated nursing staff on 5/13/2023 on the "Nail Care" policy. 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 5 residents for completion of ADL's for 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. Completed by 06/14/2023	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities.			

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	05/12/2023

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
	§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on interview and record review, the facility failed to implement an ongoing resident-centered activity program that incorporated a resident's preferences for 1 of 2 residents reviewed for activities. (Resident 21) Finding includes: Interview with Resident 21 on 5/8/23 at 10:26 a.m., indicated the resident wanted to be read to daily as she was legally blind. She had asked many staff members to read to her, however a lot of staff had refused. Resident 21's record was reviewed on 5/9/23 at 1:23 p.m. Diagnoses included, but were not limited to, glaucoma, macular degeneration, and legal blindness. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/23, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 5/12/22, indicated the resident had a visual impairment as seen by blindness and glaucoma. Interventions included, but were not limited to, keep environment free of clutter and use large print materials with resident during activities.	F 0679	**F679 Activities Meet Interest/Needs Each Resident** It is the policy of this facility that activities are provided based on the comprehensive assessment and care plan and preferences of each resident. · Resident 21 will be provided with opportunity for daily readings via electronic means and with staff as scheduling permits. Additionally, resident will be encouraged to attend the daily readings offered by the facility. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** · The Activities Director/Designee reviewed all residents care plans on 5/13/23 to make sure all residents that request daily readings have it provided. Additionally, all staff was educated on resident centered activities. · Activities Director/designee	06/14/2023

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	05/12/2023

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
	Interview with the Activity Director on 5/11/23 at 2:50 p.m., indicated the Activity Department would read to her as she requested it if no one else had read to her that day. She had informed other department staff such as the CNAs that the resident would like to be read her "Daily Devotional" every day. The Activity Department did not keep documentation related to reading to the resident daily. 3.1-33(b)(8)		will at round random audit residents requiring one on one activities for 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 B. · Completed by 06/14/2023.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to monitor, assess, and obtain treatments for diabetic ulcers at the time of admission and monitor bruises for 2 of 4 residents reviewed for non-pressure ulcers. (Residents 91 and 92) Findings include: 1. On 5/8/23 at 11:28 a.m., Resident 91 was	F 0684	**F684 Quality of Care** It is the policy of this facility that to document and monitor all residents with skin alterations and receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and residents' choices. · Resident 91 treatment orders	06/14/2023

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	05/12/2023

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
	observed in bed with his eyes closed. At that time, he was asked if he had an ulcer on his foot and indicated he did not know. CNA 1 was asked to remove the resident's socks to both of his feet. She pulled off the sock to his left foot and a large amount of flaky, dry, peeling skin flew in the air. There were dark black areas noted to several toes on his left foot. There was also a large necrotic ulcer to the bottom of his left foot. The CNA removed the sock to his right foot and again the flaky, dry, and peeling skin flew in the air. There were no open areas on his right foot. The record for Resident 91 was reviewed on 5/9/23 at 1:50 p.m. The resident was admitted to the facility on 5/6/23. Diagnoses included, but were not limited to, diabetic ketoacidosis, chronic kidney disease, type 1 diabetes, atrial fibrillation, high blood pressure, hypertensive kidney disease, and anemia. The Admission Minimum Data Set (MDS) was still progress. The Baseline Care Plan, dated 5/8/23, was still in progress and not completed. A Care Plan, dated 5/8/23, indicated the resident was admitted with a wound related to diabetic neuropathy. The Admission Assessment was not completed until 5/8/23 and 5/9/23. The skin assessment section, completed on 5/9/23, indicated the resident had a diabetic ulcer to the left plantar foot measuring 1.8 centimeters (cm) by 3.7 cm. Other skin issues were amputated toes on the right foot and the 2nd digit toe was amputated on left foot. The left great toe had a scabbed area that measured 0.2 cm by 0.2 cm, and the left pinky toe		were obtained, and the weekly wound evaluation was completed. · Resident 92 skin alterations were documented and monitored per facility policy. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** · DON /designee completed an audit on weekly skin assessment on 5/13/2023 to ensure all residents with abnormal skin conditions were documented and being monitored. All staff were re-educated on or before 5/24/2023 on the “SWAT” policy and “Skin Observation Assessment “policy monitoring of skin alterations and the skin assessment policy. Skin assessments will continue to be completed at least weekly on all residents and daily monitoring of skin during care will continue as per facility policy. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · DON/Designee will complete ongoing auditing/ monitoring 10 skin assessments for 5 days a week x 4 weeks, then weekly x 4 weeks, and then monthly x 4	

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	05/12/2023

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
	also had a scabbed area that measured 2.0 cm by 0.6 cm. There were no assessments, Physician's Orders, or documentation in the clinical record regarding the skin impairments and a treatment at the time of admission on 5/6/23. Physician's Orders, dated 5/8/23, indicated Venelex External Ointment (Balsam Peru-Castor Oil), apply to bilateral lower extremities two times a day for extremely dry skin every Tuesday, Friday, and Sunday. Physician's Orders, dated 5/9/23, indicated left foot plantar, left foot great toe, and pinky toe: cleanse with normal saline, apply skin prep and leave open to air every Tuesday, Friday and Sunday. Interview with LPN 1 on 5/8/23 at 11:39 a.m., indicated the nurse on the previous shift did not inform her the resident had an open area. She was unaware he had an open area and that his feet were extremely dry with flaky skin. Interview with the Director of Nursing on 5/8/23 at 3:00 p.m., indicated the resident was admitted on Saturday 5/6/23 and when she comes to work on Mondays, she would check the computer to make sure all Physician's Orders were correct. There should have been a treatment ordered for the ulcer and the wounds should have been measured and documented. 2. On 5/8/23 at 10:13 a.m., Resident 92 was observed in bed. At that time, there were multiple bruises observed to his left antecubital space (inner elbow) which were dark red in color. The resident indicated they were probably from the		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. · Completed by 06/14/2023.	

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	05/12/2023

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
	blood draw he had last week. The record for Resident 92 was reviewed on 5/9/23 at 1:15 p.m. The resident was admitted to the facility on 4/25/23. Diagnoses included, but were not limited to, chronic kidney disease, high blood pressure, failure to thrive, and history of transient ischemic attacks. The 5/1/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making. A Care Plan, dated 4/25/23, indicated the resident had bruise to the right upper and right lower arm. Physician's Orders, dated 4/25/23, indicated to monitor bruises to the right arm times 7 days every shift. Physician's Orders, dated 5/2/23, indicated Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP). The CMP and CBC were completed on 5/4/23. A Nursing Admission Assessment, dated 4/25/23 indicated the resident had bruising to the right upper and right lower arms with measurements. There were no bruises identified to the left arm. A Weekly Skin Assessment, dated 5/4/23, indicated there was no bruising noted. There was no documentation or an assessment of any bruises in Nursing Progress Notes dated 5/2/23-5/9/23. Interview with the Director of Nursing on 5/12/23 at 9:00 a.m., indicated the bruising to the left			

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	05/12/2023

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
	antecubital space was not assessed, measured, or monitored. Continued interview with the DON on 5/12/23 at 1:58 p.m., indicated the facility had no policy for bruises or any other non-pressure skin condition. All non-pressure skin conditions should be identified, assessed, measured and documented. The Physician was to be notified for treatment. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration flow rate for 2 of 2 residents reviewed for respiratory care. (Residents 21 and 33) Findings include: 1. On 5/8/23 at 10:19 a.m., Resident 21 was observed in her room with a nasal cannula in place. The oxygen concentrator was set to 3.5 liters per minute. Resident 21's record was reviewed on 5/9/23 at	F 0695	**F695 Respiratory Tracheostomy Care and Suctioning** It is the policy of this facility that oxygen will be administered at the ordered rate of flow per physician's order to ensure ongoing compliance. · Residents #21 and 33 had the oxygen set to the ordered rate of flow per physician's order. Care plans will be updated to indicate that the resident increases the rate of flow on their own despite being educated that doing so goes	06/14/2023

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	05/12/2023

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
	1:23 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, dementia without behavioral disturbance, and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/23, indicated the resident was cognitively intact for daily decision making. She required the use of oxygen while a resident in the facility. A Physician's Order, dated 5/2/23, indicated the resident required oxygen at 2 liters per minute per nasal cannula continuously. A Care Plan, dated 5/3/22, indicated the resident had the potential for exacerbation of chronic obstructive pulmonary disease, chronic respiratory failure, and chronic bronchitis. Interventions included, but were not limited to, administer oxygen as ordered. Interview with the Director of Nursing on 5/10/23 at 3:11 p.m., indicated she was going to look at the concentrator because they had problems in the past with faulty concentrators. The order for oxygen was 2 liters per minute and the concentrator should have been set to the correct rate. 2. On 5/8/23 at 9:55 a.m., Resident 33 was observed in his bed with a nasal cannula in place. The concentrator was set to 3 liters per minute. On 5/8/23 at 11:33 a.m., Resident 33 was observed in his bed with a nasal cannula in place. The concentrator was set to 3 liters per minute. The record for Resident 33 was reviewed on 5/9/23 at 12:41 p.m. Diagnoses included, but were not		against physicians' orders. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** · The DON/ designee completed an audit by 5/13/23 of all residents utilizing oxygen to ensure physician's order for use, that oxygen is delivered at the correct ordered liter flow, and that oxygen is included in the resident's care plan. · DON/ designee completed nursing staff in-service on or before 5/24/23 to review the "Oxygen Administration Protocol" and ensuring that residents using oxygen have physician's order for use. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · DON/Designee will complete ongoing auditing/ monitoring oxygen usage compliance per physicians' orders for 5 residents daily for 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	

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	05/12/2023

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
	limited to, type 2 diabetes mellitus, iron deficiency anemia, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 4/12/23, indicated the resident was cognitively intact for daily decision making. He required the use of oxygen therapy while a resident. A Physician's Order, dated 4/6/23, indicated the resident required oxygen at 2 liters per minute per nasal cannula continuously. A Care Plan, dated 4/7/23, indicated the resident had a decreased oxygen saturation. Interventions included, but were not limited to, administer oxygen per orders. Interview with the Director of Nursing on 5/10/23 at 3:11 p.m., indicated she would look into the concentrator because they had problems in the past with faulty concentrators. The order for oxygen was 2 liters per minute and the concentrator should have been set to the correct rate. 3.1-47(a)(6)		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. · Completed by 06/14/2023.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received scheduled medication to relieve the pain	F 0697	**F697 Pain Management** It is the policy of this facility to	06/14/2023

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	05/12/2023

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
	for 1 of 3 residents reviewed for pain. (Resident 16) Finding includes: Interview with Resident 16 on 5/8/23 at 2:07 p.m., indicated she was supposed to get her scheduled pain medicine, but there had been many times that she did not receive it because the facility indicated they had run out of the medication. Resident 16's record was reviewed on 5/9/23 at 1:46 p.m. Diagnoses included, but were not limited to, heart failure, chronic respiratory failure, gastritis (inflamed lining of stomach), and chronic kidney disease. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was cognitively intact for daily decision making. The resident had received an opioid medication daily. A Physician's Order, dated 4/18/23, indicated oxycodone-acetaminophen oral tablet 10-325 milligram (mg), 1 tablet every 8 hours. The April 2023 Medication Administration Record (MAR) indicated the resident's pain level was not assessed and the oxycodone-acetaminophen oral tablet 10-325 mg was not marked as administered on 4/25/23 at 6:15 a.m. and 2:00 p.m. The May 2023 Medication Administration Record (MAR) indicated the resident's pain level was not assessed and the oxycodone-acetaminophen oral tablet 10-325 mg was not marked as administered on 5/8/23 at 2:00 p.m. Interview with the Director of Nursing (DON) on		ensure pain management is provided to help residents achieving their optimal level of comfort by providing a pain manage program. · Resident 16 pain medication was dispensed per physicians' orders to prevent resident from unnecessary pain. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** · The audit by 5/13/23 of all residents utilizing pain medications per physician's order are being administered as scheduled. All refusals will be documented, and any new physician's order is included in the resident's care plan. · DON/ designee completed in-service for nursing staff on or before 5/24/23 to review the "Pain Medication Administration Protocol" and ensuring that pain medications are administered as ordered. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · DON/Designee will complete ongoing auditing/ monitoring pain medication administration compliance per physicians' orders	

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	05/12/2023

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
	5/12/23 at 12:55 p.m., indicated she had talked to the QMA who was working on 5/8/23 and she stated the resident was asleep and would not wake up to take her medication that afternoon. 3.1-37(a)		for 5 residents for 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 C. · Completed by 06/14/2023.	
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

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	05/12/2023

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
	reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately related to administering medications as ordered, monitoring blood glucose levels prior to the administration of insulin, and monitoring blood pressures and respiratory rates for 4 of 7 residents reviewed for unnecessary medications. (Residents 92, 18, 91 and 16) Findings include: 1. The record for Resident 92 was reviewed on 5/9/23 at 1:15 p.m. The resident was admitted to the facility on 4/25/23. Diagnoses included, but were not limited to, chronic kidney disease, high blood pressure, failure to thrive, and history of transient ischemic attacks. The 5/1/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making. A Care Plan, dated 4/25/23, indicated the resident had chronic cardiovascular disease. The approaches were to monitor vital signs at least weekly and monitor labs as ordered. A Physician's Order, dated 4/25/23, indicated Clonidine 0.1 milligrams (mg), give 1 tablet by mouth three times a day and Amlodipine 10 mg, give 1 tablet by mouth one time a day for high blood pressure. A Physician's Order, dated 5/2/23, indicated monitor blood pressures daily for 1 week and record. The only recorded blood pressures in the vital	F 0757	· **F757 Drug Regimen is Free from Unnecessary Drugs** It is the policy of this facility that each resident's drug regimen must be free from unnecessary drugs. · Resident 92 had an assessment competed; and no negative outcome noted due to the deficient practice. Blood pressure orders/parameters for med will be followed as ordered. · Resident 18 had an assessment competed; and no negative outcome noted due to the deficient practice. The physician and family were notified. Blood glucose parameters for medication will be followed as ordered by the physician. · Resident 91 had an assessment completed; and no negative outcome noted due to the deficient practice. Blood glucose monitoring will be completed per physician order. · Resident 16 had an assessment competed; and no negative outcome noted due to the deficient practice. The physician and family were notified. Respiratory rate parameters for medication will be followed as ordered by the physician. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as**	06/14/2023

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	05/12/2023

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
	sign section were on 4/25/23, 4/29/23, and 4/30/23. There was no documentation of any blood pressures from 5/2/23 to 5/8/23 in the clinical record. Interview with the Director of Nursing on 5/12/23 at 9:00 a.m., indicated the blood pressures were not checked as ordered by the Physician. 2. The record for Resident 18 was reviewed on 5/10/23 at 11:05 a.m. The resident was admitted to the facility on 4/12/23. Diagnoses included, but were not limited to, stroke, hemiplegia on the left side, vascular dementia, and contracture of the left knee and the left hand. The 4/19/23 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident was an extensive assist with a 2 person physical assist for activities of daily life (ADLs) and had physical range of motion impairment to both the upper and lower extremities on one side. In the last 7 days, the resident received insulin daily. A Care Plan, dated 4/12/23, indicated the resident had diabetes and was at risk for hypoglycemia and/or hyperglycemia. The approaches were administer insulin as ordered. A Physician's Order, dated 4/12/23, indicated Insulin Aspart (a short acting insulin) Solution 100 units/milliliter (ml), inject as per sliding scale: if less than 60 or greater than 350 call the Physician, 120 - 200 = 8 units, 201 - 250 = 10 units, 251 - 300 = 12 units, 301 - 350 = 14 units, greater than 351 = 16 units, subcutaneously three times a day. A Physician's Order, dated 4/17/23, indicated		**being negatively impacted.** · DON/Designee will complete an audit of facility insulin and blood pressure orders by 5/25/23. A review of pharmacy recommendations made were reviewed 5/12/23 and reviewed to ensure the recommendations have been addressed by the physician and properly transcribed by the nursing. · DON/Designee in-serviced nursing staff on or before 5/24/23 to review the facility policy on following physicians' orders. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · The nurse managers participate in routine audits of the MAR/TARS and will review diabetic insulin orders and blood pressure orders to ensure administration occurs as ordered. The pharmacist will continue to make monthly reviews of resident order regiments. Any pharmacy recommendations will be communicated promptly to the physician for review. The completed pharmacy recommendations will be noted by the facility charge nurse and a copy of the new order provided to the DON for review and to ensure that recommendations are completed and implemented per	

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	05/12/2023

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
	Insulin Detemir (a long acting insulin) Solution 100 units/milliliter, inject 20 unit subcutaneously every 12 hours for diabetes. The administration times were 9:00 a.m. and 9:00 p.m. The 4/2023 Medication Administration Record (MAR) indicated the Detemir insulin was coded with a "5" (meaning hold-see nurses' notes) for the p.m. dose on 4/14/23, 4/17/23, 4/18/23, and 4/19/23. On 4/21/23 the 9:00 p.m. dose of insulin was coded with a "9" (meaning see nurses' notes). The blood glucose levels on the following days after the insulin was held at 9:00 a.m. were the following: 4/15/23 the blood sugar was 186, 4/18/23 the blood sugar was 198, 4/19/23 the blood sugar was 350, and on 4/22/23 the blood sugar was 197. Nurses' Notes, dated 4/19/23 at 10:21 p.m., indicated insulin held to prevent hypoglycemia. Nurses' Notes, dated 4/21/23 at 9:06 p.m., indicated blood glucose 124. There was no documentation in Nurses' Notes on 4/14/23, 4/17/23, or 4/18/23 regarding the Detemir Insulin. The 5/2023 MAR indicated the Detemir Insulin was coded with a "9" on 5/1/23 for the p.m. dose. A Nurses' Note, dated 5/1/23 at 8:55 p.m., indicated blood glucose 123. There were no Physician's Orders in the electronic clinical record to hold the insulin. Hand written Physician's Orders were provided by the Director of Nursing (DON) on 5/12/23 at 9:00		plan of care. · DON/Designee will complete ongoing auditing/monitoring the MAR for 5 resident for 5 days a week x 4 weeks, then weekly x 4 weeks, and then monthly x 4 months to monitor ongoing compliance. Pharmacy recommendations will be audited monthly for 6 months. 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 C. · Completed by 06/14/2023.	

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	05/12/2023

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
	a.m. The following orders were noted: - 4/14/23 "hold detemir insulin at hs (night time) if blood sugar below 110." - 4/17/23 "hold detemir insulin at hs if bs (blood sugar) below 110 and refused snack." - 4/18/23 "hold detemir insulin at hs if bs below 110 and refused snack." - 4/19/23 "hold detemir insulin at hs if bs below 110." - 4/21/23 "hold detemir insulin at hs if bs below 110 and refused snack." The above Physician's Orders still had not been signed by the Physician, who had been in the facility and completed a progress note on 4/24/23. The progress note lacked documentation regarding the insulin being held or that there was a problem with the resident's blood sugar. The 4/2023 and 5/2023 MAR indicated the Aspart Insulin had not been signed out as being administered on 4/16/23, 4/20/23, and on 5/4/23 for the mid day dose. Interview with the DON on 5/12/23 at 9:00 a.m., indicated she had spoken to the evening shift nurses who told her they hand wrote Physician's Orders to hold the resident's insulin if her blood glucose level was under 110. She had no idea the orders were hand written and was unaware the resident's blood sugar was very high the next morning after the Detemir insulin was held. The Physician had not signed the hand written orders, nor had he made any mention of the blood sugars in his note on 4/24/23. She indicated both insulins were to be administered as ordered by the Physician. 3. The record for Resident 91 was reviewed on			

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	05/12/2023

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
	5/9/23 at 1:50 p.m. The resident was admitted to the facility on 5/6/23. Diagnoses included, but were not limited to, diabetic ketoacidosis, chronic kidney disease, type 1 diabetes, atrial fibrillation, high blood pressure, hypertensive kidney disease, and anemia. The Admission Minimum Data Set (MDS) was still in progress. A Care Plan, dated 5/6/23, indicated the resident had diabetes and was at risk for hypoglycemia and/or hyperglycemia. The approaches were to administer insulin as ordered. Physician's Orders, dated 5/7/23, indicated Insulin Glargine (a long acting insulin) Subcutaneous Solution Pen-injector 100 units/milliliters (ml), inject 24 unit subcutaneously two times a day and Insulin Aspart (a short acting insulin) Injection Solution 100 units/ml, inject 16 unit subcutaneously three times a day. There were no orders for blood glucose monitoring prior to the administration of the insulin. Discharge notes/instructions from the hospital, dated 5/6/23, indicated blood glucose monitoring as directed. Insulin Glargine 24 units two times a day and it was last administered on 5/6/23 at 8:36 a.m. Insulin Aspart 12 units were administered last on 5/6/23 at 8:36 a.m. Blood glucose levels were recorded in the vital sign section on 5/7/23 at 4:40 a.m., 5:55 p.m., and 9:18 p.m. There were no other blood glucose levels available for review. The Medication Administration Record (MAR),			

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	05/12/2023

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
	dated 5/2023, indicated the Insulin Aspart was to be administered at 9 a.m., 1 p.m., and 5 p.m. There was no insulin administered on 5/6/23. The 5/7/23 9:00 a.m., dose was coded with a "13" (meaning outside of parameters) and on 5/8/23 at 5 p.m., the dose was coded with a "9" (meaning see nurses' notes). Nurses' Notes, dated 5/8/23 at 8:43 p.m., indicated did not administer Aspart Insulin due to blood glucose was 132. The 5/2023 MAR indicated the Insulin Glargine not administered at all on 5/6/23 and was first administered on 5/7/23 at 9:15 p.m. Interview with LPN 1 on 5/9/23 at 3:00 p.m., indicated she checked the resident's blood sugar this morning before the 9 a.m. dose and it was 176. She indicated there was no place in the electronic clinical record to document the blood sugar levels but she knew since he was receiving insulin, she had to check his blood sugar. Interview with the Director of Nursing (DON) on 5/10/23 at 8:30 a.m., indicated she would have expected the nursing staff to check the resident's blood sugar before administering the insulin. Continued interview with the DON on 5/12/23 at 9 a.m., indicated the resident's insulin should have been administered as ordered by the Physician.4. Resident 16's record was reviewed on 5/9/23 at 1:46 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, chronic kidney disease, dementia without behavioral disturbance, anxiety disorder, high blood pressure, depressive episodes. The Significant Change in Status Minimum Data			

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	05/12/2023

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
	Set (MDS) assessment, dated 2/15/23, indicated the resident was cognitively intact for daily decision making. She received an opioid and anti-anxiety medication daily. A Physician's Order, dated 4/18/23, indicated oxycodone-acetaminophen (pain medication) oral tablet 10-325 milligram (mg), 1 tablet every 8 hours. Hold if respiratory rate was less than 12 breaths per minute, then notify the physician. A Physician's Order, dated 4/18/23, indicated alprazolam (anti-anxiety medication) 1 mg one time a day. Hold if respiratory rate was less than 12 breaths per minute, then notify the physician. The last recorded respiratory rate was documented on 2/14/23 at 2:35 p.m. in the Weights/Vitals section of the Electronic Health Record (EHR). The April and May 2023 Medication Administration Record (MAR) had no documentation of respiratory rates. Interview with the Director of Nursing on 5/11/23 at 1:44 p.m., indicated she expected that nursing staff would document if the respiratory rate was less than 12 and call the Physician, however there was no documentation for routine respiratory rates recorded in the chart upon administration of the medications. 3.1-48(a)(6)			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician			

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	05/12/2023

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
	assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure the Physician was promptly notified of abnormal laboratory results for 1 of 7 residents reviewed for unnecessary medications. (Resident 92) Finding includes: The record for Resident 92 was reviewed on 5/9/23 at 1:15 p.m. The resident was admitted to the facility on 4/25/23. Diagnoses included, but were not limited to, chronic kidney disease, failure to thrive, and history of transient ischemic attacks. The 5/1/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making. A Care Plan, dated 4/25/23, indicated the resident had chronic cardiovascular disease. The approaches were to monitor vital signs at least weekly and monitor labs as ordered. A Physician's Order, dated 5/2/23, indicated Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP). The CMP and CBC were completed on 5/4/23 with abnormal results as follows: - Potassium level was 5.1 (normal 3.6-5)	F 0773	**F773 Lab Services Physician/Notify of Results** It is the policy of facility to provide laboratory services only when ordered by physician, PA, NP or clinical nurse specialist in accordance with State law and scope of practice. The facility is responsible to promptly notify the ordering provider with results that fall outside reference ranges in accordance with facility policy and procedures for notification to the practitioner or per ordering physician. · Resident # 92: Current labs were reviewed and all future lab results with results falling outside reference ranges will be communicated to the physician promptly when results become available and are communicated to the facility. All residents are at risk to be affected by the deficient practice. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.**	06/14/2023

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	05/12/2023

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
	- Blood Urea Nitrogen (BUN) was 34 (normal 7-28) - Creatinine (CR) was 1.7 (normal 0.44-1.32) - Hemoglobin was 13.2 (normal 14-18) The Physician was notified of the results on 5/10/23 (6 days after the labs were drawn). Interview with the Director of Nursing on 5/11/23 at 8:30 a.m., indicated she had to call the lab to get the results as they did not fax them over. It was the nurses' responsibility to make sure the results were reported timely to the Physician. 3.1-5(a)(3)		· The DON/designee completed a review of all laboratory/diagnostic testing physician orders by 5/24/2023to ensure orders are current and communicated to the physician per policy and is documented in the EMR. All licensed nurses participated in education by 5/24/23 to review the facility policy for “Physician Notification of Change” and “Laboratory Orders” which included education on tracking tool to ensure timely collection and notification of laboratory results. · DON/designee in-service nursing staff on the importance of documenting in EMR notification to the physician for all critical lab values, abnormal radiology or diagnostic testing results, and any need to alter resident treatment significantly. The DON or other designee routinely reviews the EMR/24hr report to monitor for continued compliance with prompt physician notification per policy. The Laboratory tracking tool (Attachment E) will be utilized by the charge nurses during report to communicate any new lab/diagnostic testing orders and pending results to ensure nurses are responsible to follow up on results timely and communicate to MD promptly upon receipt. Any staff who fail to comply with the	

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	05/12/2023

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
			points of the in-service will be further educated and or progressively disciplined as indicated. · DON/Designee will complete ongoing auditing/monitoring "Notification of Changes" for 5 resident for 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 C. · Completed by 06/14/2023.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	05/12/2023

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
	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen for food preparation related to trash behind the stove, grease on the vent hood above the stove, and dried food spillage on the steam table in 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect all 46 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 5/08/23 at 9:20 a.m., with dietary manager, the following was observed: a. There was trash on the floor behind the stove. b. There was grease on the vent hood above the stove. c. There was dried food spillage on the steam table. Interview with the Dietary Manager at that time, indicated she would clean the areas and there should not have been trash on the floor. 3.1-21(i)(3)	F 0812	· **F812 Food Procurement, Store/Prepare/Serve Sanitary** It is the policy of this facility that food is stored, prepared, distributed and served to residents in accordance with food service safety. This had the potential to affect all residents. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted.** ·The trash on the floor behind the stove was removed. ·The grease on the hood vent was cleaned and will be cleaned monthly and as needed to prevent buildup. The slats will be removed from the hood and sent through the dish machine. The hood will be examined weekly and if a problem is seen maintenance will be notified Immediately. ·The dried food spillage on the steam table was cleaned and any future spills on the stand for the steamer should be wiped	06/14/2023

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	05/12/2023

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
			· Dietary Manager/Designee will in-service all dietary staff on or before 5/24/23 on “Kitchen Sanitation Check List”. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · Dietary Manager/Designee will complete ongoing auditing/monitoring “Kitchen Sanitation Audit” for 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 D.	
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.			

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	05/12/2023

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
	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 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			

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	05/12/2023

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
	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 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 record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not completing the respiratory screening assessments for 2 of 2 residents reviewed for COVID-19. (Residents 242 and 35) Findings include: 1. The record for Resident 242 was reviewed on 5/11/23 at 2:05 p.m. The resident was admitted to the facility on 4/21/23. Diagnoses included, but were not limited to, COPD, high blood pressure, dependence on oxygen, and COVID-19. A COVID-19 Symptom Screener for Positive Residents Assessment, dated 5/3/23 at 3:21 p.m., indicated the resident tested positive for COVID-19.	F 0880	**F880 Infection Prevention & Control** It is the policy of this facility to ensure infection control guidelines are in place to ensure infection control guidelines are in place and implemented, including those to prevent and/or contain COVID-19 and completing the respiratory screening assessments. · Resident 242 respiratory assessment was completed. · Resident 35 respiratory assessment was completed. **All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as**	06/14/2023

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	05/12/2023

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
	A Physician's Order, dated 4/21/23, indicated COVID-19 test as needed for COVID-19 screening. A Physician's Order, dated 5/3/23, indicated "Isolation: Contact - In a single room and not allowed to leave room - stop sign in place on door. All services provided in room." The COVID-19 Symptom Screener for Positive Residents Assessments were completed on the following days: - 5/3/23 at 10:48 p.m. - 5/4/23 at 10:47 p.m. - 5/5/23 at 10:47 p.m. - 5/6/23 at 9:42 a.m. - 5/7/23 at 8:32 a.m. - 5/7/23 at 9:00 a.m. - 5/8/23 at 6:39 p.m. There was no documentation of COVID-19 Symptom Screener Assessment completed every shift which included a respiratory assessment of the resident. Interview with the Infection Preventionist on 5/11/2232 at 2:35 p.m., indicated the COVID-19 Symptom Screener Assessments were to be completed every shift when a resident had tested positive for COVID-19.2. Interview with Resident 35 on 5/8/23 at 3:06 p.m., indicated she tested positive for COVID-19 on 5/3/23 and the staff were only checking her vital signs daily. Resident 35's record was reviewed on 5/10/23 at 2:51 p.m. Diagnoses included, but were not limited to, COVID-19, fracture of shaft of left femur, fracture of upper end of left ulna, and tachycardia. The Admission Minimum Data Set (MDS)		**being negatively impacted.** · DON/Designee audited all COVID-19 resident respiratory screening assessments to ensure completion on 5/13/23. · DON/Designee in-service nursing staff on or before 5/24/23 to review the “COVID-19 Symptom Screener for suspected residents”. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. · DON/Designee will complete ongoing auditing/monitoring “Completion of COVID-19 Respiratory Assessment” for 5 residents for 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 C. Completed by 06/14/2023	

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	05/12/2023

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
	assessment, dated 4/13/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 5/3/23, indicated "Isolation: Contact - In a single room and not allowed to leave room-stop sign in place on door. All services provided in room." A Physician's Order, dated 5/3/23, indicated for COVID-19 positive residents record temperature, pulse, respirations, blood pressure, and oxygen saturation every shift. A Physician's Order, dated 5/5/23, indicated monitor for COVID-19 signs and symptoms every night shift. A COVID-19 Symptom Screener for Positive Residents was completed on 5/3/23 at 12:51 p.m. There was no documentation of COVID-19 Symptom Screener Assessment completed every shift and included a respiratory assessment of the resident. Interview with the Infection Preventionist on 5/11/2232 at 2:35 p.m., indicated the COVID-19 symptom screener assessments were to be completed every shift for COVID-19 positive residents. The Policy titled, "COVID-19 Resident and Staff Guidance/Outbreak Protocol," noted as current, indicated "...COVID-19 Positive: COVID UDA Requirements: 1. COVID 19 Symptom Screen for Positive Residents BID (twice a day)..." 3.1-18(b)			