STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. BUILDING 00 B. WING	04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00406798. Complaint IN00406798 - Federal/state deficiencies related to the allegations are cited at F684. Survey date: April 24, 2023 Facility number: 000519 Provider number: 155571 AIM number: 100287230 Census Bed Type: SNF/NF: 35 SNF: 2 Total: 37 Census Payor Type: Medicare: 3 Medicaid: 31 Other: 3 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 1, 2023.	F 0000		
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			

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

Tyisha Wheeler | Administrator | 05/17/2023

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.

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to assess and document bruising of unknown origin to a resident's hand for 1 of 3 residents reviewed for accidents (Resident B). Findings include: Resident B's clinical record was reviewed on 4/24/23 at 9:03 a.m. Diagnoses included Alzheimer's disease with early onset, vascular dementia, unspecified severity, with other behavioral disturbance, other seizures, major depressive disorder, single episode, and epilepsy, unspecified, not intractable, without status epilepticus. Her current medications included, citalopram hydrobromide (treat depression) 20 mg (milligram) daily, levetiracetam (treat seizures) 500 mg twice daily, and mirtazapine (treat depression) 30 mg daily. An admission skin assessment, dated 4/8/23, indicated she had unspecified bruises and three tattoos. A nurses note, dated 4/10/23 at 12:35 p.m., indicated she was not responding to staff. The hospice aide gave her a shower. She was a heavy assist of two staff members with transfers, but the hospice aide indicated she ambulated to bathroom when she was at home. She had no signs or symptoms of pain or discomfort and she had no skin issues. A nurses note, dated 4/11/23 at 9:59 a.m., indicated she was alert to her name. She was	F 0684	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility is respectfully requesting a desk review for all deficiencies in the Plan of Correction.* **F684: It is the policy of this facility to assess, document, and monitor bruises and alteration in skin integrity.** **Resident B has since been discharged from the facility due to respite stay ending** **This deficient practice has the potential to affect all residents in the facility. A facility wide skin sweep was completed on 5-11-23, and any new areas will be monitored and documented per facility policy.** **Administrator educated facility staff 5-12-23 (Attachment A) on the importance of reporting bruising when immediately noticed, proper documentation**	05/16/2023

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	restless and walked the hallways with one to two assistance of staff. Her gait was very unsteady. She had anxiety and was given antianxiety medication with some effectiveness. She had been on one on one with staff, and she attempted to walk or transfer without assistance and without regards to safety. On 4/13/23 at 8:15 p.m., she discharged home. During an interview with LPN 23, on 4/24/23 at 9:25 a.m., she indicated on Monday 4/10/23, she had noticed light purple bruising to Resident B's thumb and around to her pointer finger. She was not sure which hand it was. The resident tried to get up a lot while she was at the facility, but she did not have any falls and there was no abuse reported to her. During an interview with LPN 15, on 4/24/23 at 9:36 a.m., she indicated Resident B had dark purple bruising on her hand. The hospice aide had mentioned it to her, and LPN 15 thought she admitted with it, and it could have been from a blood draw. During an interview with the ADON, on 4/24/23 at 9:43 a.m., she indicated she had noticed bruising located on her hand in passing but was not sure which hand it was, but thought it was her right hand. They thought she had a blood draw prior to admitting to the facility. They would normally document bruising. There was no abuse, nor any falls or seizures, while she was at the facility. Resident B was, for the most part, non-responsive and they could barely get her to eat. Then, on Tuesday 4/11/23, she was up and going. During an interview with the hospice aide, on 4/24/23 at 12:22 p.m., she indicated she was		**of skin issues and/or bruising and notification to all parties per policy. Additionally, any employee who fails to comply with the points of this in-service may be further educated and/or progressively disciplined as indicated.** **DON/Designee will audit weekly skin assessment (Attachment B) 5 times a week for 6 months during Clinical Meeting. Any identified concerns will be addressed immediately and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted an action plan may be established.** **Date of Compliance: 5-16-23**	

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	Resident B's aide at the facility and at her home. She was at the facility on Monday 4/10/23 and did not notice the bruise. On Wednesday 4/12/23, her right hand was swollen and black and blue, so she went to LPN 15, and she indicated to her it could have been from a lab draw. She had existing bruising to her left hand when she admitted to the facility. During an interview with LPN 23, on 4/24/23 at 2:20 p.m., she indicated they would normally document bruising when a resident was admitted or when bruising was noticed. During an interview with the DON, on 4/24/23 at 2:24 p.m., she indicated, on 4/10/23, she noticed a bruise to Resident B's right hand. She went to the shower room with the aide and asked Resident B questions and looked at her bottom. She assumed the bruising was from a lab draw that may have been drawn while she was at home. The bruise on the top of her right hand wasn't completely black and blue, but it was darker. It did get darker and darker as the week went on. Resident B did not complain of pain. Normally, they would chart bruising and she should had charted it on Monday when she noticed it. During an interview with LPN 27, on 4/24/23 at 2:45 p.m., she indicated she did not notice a bruise to the resident's right hand when she admitted to the facility. She did a thorough skin check on Resident B. When she did skin checks, she basically disrobed the resident, including checking their heels, elbows, and back. During an interview with CNA 17, on 4/24/23 at 4:23 p.m., she indicated she had noticed a bruise on the top of Resident B's right hand, and it was swollen and it didn't look fresh. She reported to			

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	the bruising to LPN 23 and she told her that she already knew about it. A family member came to pick her up on 4/13/23. The family member noticed the bruise to her right hand and was surprised. The family member asked what had happened to her hand. CNA 17 told her told her that the nurse said it was already there. The family member indicated it had not been there prior to admission. A review of a hospital history of present illness document, dated 4/14/23 at 1:31 p.m., indicated Resident B was on hospice due to terminal illness and was at a nursing home for respite care. A significant bruise was noticed over her right hand and wrist at discharge from the facility. No one seemed to know how she received the bruising. The bruise was dark brown, so it had occurred several days ago. A right wrist x-ray was performed. The impression of the x-ray indicated displaced and overriding comminuted fracture at the base of the first metacarpal (fracture dislocation of the right thumb). An undated, current, facility policy titled "SKIN OBSERVATION/ASSESSMENT," provided by the DON on 4/24/23 at 3:58 p.m., indicated the following: "Policy...Conditions that will be observed for include, but are not limited to, what appear to the care giver to be bruises...discoloration...Note...the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain any needed orders for treatment. Appropriate documentation and care planning will be completed as per policy...." This Federal tag relates to complaint IN00406798. 3.1-37(a)			

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