STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440436. Complaint IN00440436 - Federal/state deficiencies related to the allegations are cited at F610 and F744. Survey dates: 8/8/24 and 8/9/24 Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census Bed Type: SNF/NF:46 SNF:2 Total:48 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 4 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 16, 2024.	F 0000	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 compliance with State and Federal Laws. Facility's date of alleged compliance is (8-10-2024). The facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryce Tomasi	Administrator	08/29/2024

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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	§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure staff reported a resident-to-resident altercation to the Administrator immediately, delaying the submission of the incident within the required timeframe to the Indiana Department of Health for 1 of 3 incidents reviewed. (Resident B and Resident C) Findings include: The clinical record for Resident C was reviewed on 8/8/24 at 10:54 a.m. Diagnoses included anxiety, major depressive disorder, and dementia. A late entry progress note, dated 8/1/24 at 11:45 p.m., indicated on 7/9/24 at 11:42 p.m., Resident C was in an altercation with another resident. Resident C was in no distress and did not have any memory of the incident happening. Staff would continue to monitor the resident. Review of a facility self-reportable, dated 7/29/24, indicated on 7/29/24 Resident B was standing close to Resident C and Resident C then pressed his hands onto Resident B's chest. The administrator submitted the reportable to the	F 0610	F-610 It is the intent facility failed to ensure staff report a resident-to-resident altercation to the Administrator immediately, to prevent delaying the submission of the incident within the required timeframe to the Indiana Department of Health. 1. Resident B and C were assessed by the nurse on 7-29-2024, no negative outcome from the cited practice, the ADM/designee completed the report to the stage agency on 7-29-2024. 2. All Residents have the potential to affected by the alleged practice, therefore, this plan o correction applies to all residents that reside in the facility. 3. The Administrator/DON educated all staff on reporting guidelines per policy and the abuse policy on 8-29-2024. Additionally, any employee who fails to comply with the points of	08/10/2024

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	Indiana Department of Health (IDOH) on 7/29/24 at 12:39 p.m. The clinical record for Resident B was reviewed on 8/8/24 at 10:50 a.m. Diagnoses included anxiety, depression, and dementia. During an interview, on 8/8/24 at 12:21 p.m., the Psychiatric NP indicated she was notified that there had been some animosity between Resident B and Resident C. Resident B was agitated walking up and down the hallway, after she left, the facility notified her that Resident B had punched another resident, and she gave an order to administer Haldol and send out to the hospital if ineffective. During an interview, on 8/8/24 at 12:44 p.m., LPN 3 indicated Resident B was very agitated and was up in another resident's face on 7/9/24. During an interview, on 8/8/24 at 3:21 p.m., QMA 1 indicated, on 7/9/24, Resident B was wandering down the hall and entered Resident C's room. Resident C was coming out of the bathroom when Resident B swung and struck Resident C on the shoulder or chest area. Resident C then grabbed Resident B by the shoulder and slammed him on the bed. Resident B and Resident C were separated. Resident C was yelling that Resident B attacked him, they were able to get Resident C calmed down and separated from Resident B. LPN 3 came to the dementia unit after receiving the call and notified the Social Services Director regarding the incident. During an interview, on 8/9/24 at 9:01 a.m., the Administrator indicated the facility needed to report any abuse, accidents, resident to resident altercations, falls with injury and unusual		the in-service may be further educated and/or progressively disciplined as indicated. 4. Administrator/Designee will interview 10 random staff members weekly x 4 weeks to ensure timely notification of abuse, then 5 random staff members weekly x 4weeks, then 5 rando staff members monthly x 4 months, these interviews will be conducted on random shifts.. If the facility is within 95% compliance at the end of the 6 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 will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 8-10-2024	

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	occurrences to IDOH. He did investigate the resident-to-resident altercation when he was made aware, which was on 7/29/24. QMA 1 would have been interviewed, but no longer worked at the facility. The Administrator listed the date of 7/29/24 on the facility self-reportable as the date of occurrence because that was the day he was made aware of the altercation. During an interview, on 8/9/24 at 9:28 a.m., CNA 2 indicated Resident B pushed resident C down to the ground. Resident C got back up and pushed Resident B back. LPN 3 was notified about the physical altercation between Resident B and Resident C. During an interview, on 8/9/24 at 9:45 a.m., LPN 3 indicated she would not report anything that she did not physically see herself. If she saw any type of altercation or abuse, she would notify the DON. During an interview, on 8/9/24 at 10:06 a.m., CNA 20 indicated she followed the chain of command, and the nurse reported any incidents to the Administrator or DON. During an interview, on 8/9/24 at 10:30 a.m., LPN 2 indicated any type of resident-to-resident altercation was reported immediately to the Administrator, Social Services Director, and DON. During employee record review, on 8/9/24 at 11:26 a.m., CNA 20 and LPN 3 attended abuse in-service training on 7/25/24. QMA 1 and CNA 2 attended abuse in-service training on 10/26/23. A current facility policy, titled Abuse Reporting Policy", provided by the Administrator on 8/9/24 at 11:24 a.m., indicated the following: "...All alleged violations involving mistreatment, abuse,			

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	neglect, misappropriation of resident property and any injuries of an unknown origin MUST be reported to the Administrator and Director of Nursing. The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or to the individual in charge of the facility during the Administrator's absence .... The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator or individual in charge of the facility within 24 hours of the occurrence of such incident ...." This citation relates to Complaint IN00440436. 3.1-28(c)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to develop and implement individualized non- pharmacological interventions for behaviors for residents with dementia for 1 or 3 residents reviewed for dementia care (Resident B and Resident C).	F 0744	F-744 It is the intent of the facility to ensure the facility to develop and implement individualized non-pharmacological interventions for behaviors for residents with	08/10/2024

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	Findings include: During a random observation, on 8/8/24 at 10:54 a.m., Resident B was sitting in the main dining room. On 8/8/24 at 11:07 a.m., Resident B was wandering around the unit and he went behind where Resident C was sitting in the common area. Resident C started to get up out of his chair but LPN 2 told him to sit back down. Resident B then went around and started touching another resident's walker. Resident C got out of his chair to go over to where Resident B was located. LPN 2 got in between Resident B and Resident C. LPN 2 was able to get Resident C to sit back down in his chair. Resident C stated, "he is a pain in the a--". On 8/8/24 at 9:57 a.m., Resident B was fidgeting with things at the nurse's station before walking independently up and down the hallway. Review of Resident B's clinical record was completed on 8/8/24 at 10:50 a.m. Diagnoses included depression, dementia, anxiety and seizures. Current medication orders included, but were not limited to, sertraline (antidepressant) 100 mg (milligrams) one tablet daily, memantine (dementia) 10 mg one tablet twice daily, Vimpat (anti-epileptic) 100 mg one table twice daily, lorazepam (antianxiety) 1 mg one table twice daily, and donepezil (memory loss and confusion) 10 mg one table daily at bedtime. He had physician ordered behavior monitoring for target behaviors of intrusive wondering, anxiety,		dementia. Corrective Actions Taken 1. DON/Designee reviewed and updated resident B and C with individualized non-pharmacological interventions for behavior management on 8-10-2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 2. The DON/Designee completed an audit of residents with dementia's care plans and updated with non-pharmacological interventions related to behavior management on 8-10-2024. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 3. The Administrator/DON educated Nursing staff/SSD on non-pharmacological interventions for behaviors on 8-29-2024. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 4. DON/Designee will audit 10 random residents care plans for residents with dementia and behaviors for non-pharmacological	

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	non-compliant with care and redirection, pacing. A 6/6/24, admission, Minimum Data Set (MDS) assessment indicated he wandered daily. A progress note, dated 6/20/24 at 8:38 p.m., indicated Resident C was having aggression towards him (Resident B). A progress note, dated 7/9/24 at 10:21 a.m., indicated Resident B was given an injection of 2.5 milliliters (mL) of Haldol (antipsychotic). The Psychiatric Nurse Practitioner (NP) observed Resident B's behavior after writer assisted the QMA in getting the resident dressed. Resident B continued having behaviors and had gotten a pencil and appeared to be holding it as if wanting to stab someone with it. The Psychiatric NP ordered another injection of Haldol at that time. A physician's note, dated 7/9/24 at 9:20 a.m., indicated Resident B was agitated and restless. Staff reported agitation over putting on his socks. He was pacing and staff witnessed him going back and forth to the exit doors and shaking them in an attempt to open the doors. An order was given for Haldol 2.5 milligram (mg) IM (intramuscularly). After the NP left the facility, she was notified that Resident B was still agitated, punched another resident, and had a pencil in his pocket. An order was given to administer a second dose of Haldol and to send to the hospital if ineffective. Resident B's care plan lacked interventions related to increased agitation and aggression with another resident. Review of Resident C's clinical record was completed on 8/8/24 at 10:54 a.m. Diagnoses		interventions 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 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 will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date of Compliance: 8-10-2024	

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	included dementia with other behavioral disturbances, major depressive disorder and anxiety. Current medication orders included, but were not limited to, sertraline (antidepressant) 50 mg (milligrams) one tablet daily, lisinopril (hypertension) 10 mg one tablet daily and donepezil (memory loss and confusion) 10 mg one table daily at bedtime. He had physician ordered behavior monitoring for target behaviors of depressive mood, anxiety, agitation and non-compliance. A 6/27/24, quarterly, Minimum Data Set (MDS) assessment indicated he was not having any physical, verbal, or other behavioral symptoms toward others. A progress note, dated 6/20/24 at 8:38 p.m., indicated he was aggressive towards Resident B. A progress note, dated 7/9/24 11:42 p.m., indicated the resident was in an altercation with another resident. There was no distress or memory of the incident. Staff would continue to follow up. Resident C's care plan lacked interventions related to behavior. No behaviors were documented under the Behavior Monitoring order for July 2024. During an interview, on 8/8/24 at 11:07 a.m., LPN 1 indicated that Resident B walked from the time he got up until the time he went to bed. He wandered into other resident rooms if their doors were left open. He was easily redirected. Resident C did not have any behaviors. He was overly protective of			

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	the female residents on the unit. The nurse had previously had to get between Resident B and Resident C five times already today. During an interview, on 8/8/24 2:29 p.m., the Social Services Director indicated the residents care plan should match the orders for behavior monitoring. The care plan should have been updated with a new intervention. They would add physical contact with another resident and that would be updated on his behavior monitoring order. During an interview, on 8/9/24 at 9:01 a.m., the Administrator indicated there should have been a summarization in the progress notes regarding their behaviors and the interventions that were used. During an interview, on 8/9/24 at 9:11 a.m., the DON indicated staff was unsure who should be documenting behaviors under the behavior monitoring. The care plan should have been updated with new interventions on their behaviors the next day. During an interview, on 8/9/24 at 9:28 a.m., CNA 2 indicated that Resident B was always wandering around walking and getting into things. He was normally easily redirected. He liked to talk about work and tinker with little toys. During an interview, on 8/9/24 at 9:45 a.m., LPN 3 indicated she was unsure who was to document residents' behavior monitoring. She would not chart something that she was told, she must physically see it herself before she would chart it. A current policy, titled "Behavior Management Program," provided by the Administrator on 8/9/24 at 9:10 a.m., indicated the following: "...Each			

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	resident of the facility identified as exhibiting problematic behavior will be observed in a manner to identify the casual factor, if possible, of the behavior as well as seek approaches/interventions appropriate for the same. When a resident exhibits problematic behavior, the same is addressed on the 24-hour report and in the resident's medical record ...." This citation relates to Complaint IN00440436. 3.1-37(a)			