STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 5, and 8, 2024 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 4 Medicaid: 51 Other: 5 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 16, 2024.	F 0000	I would like to respectfully request paper compliance for our survey. Thank you.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Thomas	Executive Director	01/28/2024

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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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to implement care plan approaches to prevent falls for 1 of 3 residents	F 0656	Neither signing nor submission of this plan of correction shall constitute an admission of any	01/29/2024

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	reviewed for accident prevention. (Resident 51) Findings include: Resident 51's clinical record was reviewed on 1/4/24 at 10:52 a.m. Current diagnoses included, dementia, difficulty walking, weakness, and low back pain. The resident had a history of falls, fall events, and injuries of unknown origins as follows: 7/7/23-The resident had a fall in the shower room. 7/31/23- The resident stumble with his walker entering his room and landed on his knees. 8/13/23-The resident was found on the floor by his bed. 10/7/23- The resident had an unwitnessed fall. 11/27/23- The resident had fall in the hallway which resulted in a skin tear. 12/4/23-The resident had an unwitnessed accident which resulted in a laceration on his forehead and abrasion on his nose. A 12/5/23, 7:48 p.m. IDT (Inter Disciplinary Team) progress note indicated the most likely cause for the injury was an unwitnessed fall. The resident had a current care plan problem/need regarding the risk for falls and related injury, initiated 9/16/22. Approaches to this problem included brightly colored signage on walker to encourage use (11/27/23) and non-skid strips on floor next to bed (10/9/23). A 12/5/23, quarterly, Minimum Data Set (MDS)		deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The non-skid strips and the sign on the walker were immediately replaced when the issues were reported for resident #51. 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; All residents with falls have the potential to be affected. An audit of fall interventions was completed by the DNS on 1/22/24 to ensure all fall interventions are in place in accordance with the resident's plan of care. No other residents were found to be affected. Had issues been found they would have been corrected immediately. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	

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	assessment indicated the resident was cognitively impaired, was rarely or never understood by others, used a walker for mobility, and rejected care 1 to 3 days of the assessment period. During the survey period from 1/4/24 at 11:01 a.m. until 1/8/24 at 10:01 a.m., floor strips were not present on the floor by the resident's bed. There was no visible signs of adhesive residue on the floor where strips had been removed. During an observation on 1/4/24 at 11:16 a.m., the resident was in the dining room with his walker near his dining seat. There was no bright signage on the walker. During an observation on 1/5/24 at 11:44 a.m., the resident was in the dining room with his walker near his dining seat. There was no bright signage on the walker. During an observation and interview on 1/8/23 at 10:01 a.m., RN 5 indicated there were no non-skid strips by Resident 51's bed. The resident was resting in the bed at the time. RN 5 looked at the resident's walker and indicated there was no bright signage or any signage posted. She did not remember the last time she had seen either item in place. During an interview on 1/8/24 at 10:07 a.m., the Dementia Unit Manager indicated she did not know why Resident 51 did not have non-skid strips on his floor nor signage on his walker. The CNA assignment sheet specifically identified needed tools and devices. If a staff member noticed these items were missing, they should notify the charge nurse or unit manager to correct the problem.		recur; Each member of the IDT has been assigned a set of rooms to inspect for fall interventions and other important items to check, and the IDT team was in-serviced on 1/15/24 per ED/DNS on weekly environmental checks of resident rooms for fall interventions. New Fall sites will be visited at daily during clinical meeting by the Nursing IDT to ensure fall interventions in place. The Assigned IDT member will complete weekly environmental checks of resident rooms to ensure fall interventions in place per resident profile. 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; On going compliance with this corrective action will be monitored via scheduled facility QAPI program and is overseen by the Executive Director. Fall audit Tools will be completed weekly x 4 weeks and then month x 6 months and then quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	Review of the CNA assignment sheet provided by the Dementia Unit Manager on 1/8/24 at 10:10 a.m. indicated Resident 51 should have brightly colored signage on walker to encourage use and non-skid strips next to bed. During an interview on 1/8/24 at 10:33 a.m., the DON indicated she did not know why the bright signage or non-skid strips were not in place. She reviewed the resident's record and the resident's bed placement was changed on 12/4/23 as an intervention. Perhaps the placement of the non-skip strips in the new location was accidentally overlooked. A current, 8/2022, policy titled, "Fall Management Policy," provided by the DON on 1/8/24 at 10:40 a.m., indicated the following: "...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...." 3.1-35(b)(1)			
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, interview, and record review, the facility failed to ensure oxygen therapy was administered according to physician order for	F 0695	Neither signing nor submission of this plan of correction shall constitute an admission of any	01/29/2024

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	1 of 1 resident reviewed for oxygen therapy. (Resident 22) Finding includes: During an observation on 1/3/23 at 3:26 p.m., Resident 22 was in bed in her room. Her oxygen was on via nasal cannula and set at 4 liters per minute. The oxygen concentrator was to the left of the resident's bed. During an interview at the time of observation, the resident indicated she had trouble with staff putting her oxygen on in the mornings because they failed to adjust the oxygen setting once they removed the Trilogy (non-invasive mechanical ventilator) mask. She was unable to ambulate, and the oxygen concentrator was not within reach. She relied on staff to manage her respiratory equipment. During an observation on 1/4/23 at 8:09 a.m., the resident was in bed with her oxygen on via nasal cannula at 4 liters per minute. The resident indicated staff had just removed her Trilogy mask and put the nasal cannula on her. Resident 22's clinical record was reviewed on 1/4/24 at 11:35 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), shortness of breath, multiple sclerosis, and generalized muscle weakness. An order, dated 1/26/22, indicated Trilogy on at bedtime and off upon waking with oxygen at 4 liters per minute. An order, dated 11/22/22, indicated oxygen at 3 liters per minute was to be worn daily via nasal cannula. An annual Minimum Data Set assessment, dated		deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Oxygen and Trilogy order was reviewed and clarified for resident #22 by her primary physician. 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; All residents receiving oxygen therapy have the potential to be affected. An Audit was completed by the DNS on 1/22/24 of residents receiving oxygen therapy to ensure orders and flow rates were correct and clearly stated per order. All Nursing staff were in-serviced by the DNS/Designee on oxygen therapy, flow rates per order by 1/9/24. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	

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	11/9/23, indicated the resident was cognitively intact. She was dependent for toileting, personal hygiene, and lower body dressing. The resident was dependent on staff to roll left and right and to move from sitting to lying. Chair transfers, toilet transfers, and sit to stand transfers were not attempted due to the resident's medical condition. Special treatments included oxygen therapy and a non-invasive mechanical ventilator. A care plan, revised 12/27/23, indicated the resident was at risk for impaired gas exchange related to COPD with shortness of breath. Interventions included administer oxygen as ordered (11/16/21), and Trilogy machine for sleep apnea (3/1/23). A Nurse's Note, dated 10/10/23, indicated the resident's oxygen was on at 4 liters per minute via nasal cannula. During an observation on 1/5/24 at 9:18 a.m., the resident was in bed with oxygen on at 4 liters per minute via nasal cannula. The resident indicated staff had removed her Trilogy mask for her that morning and placed the nasal cannula on her. During an interview at the time of observation on 1/5/24 at 2:54 p.m., LPN 2 indicated the resident's oxygen via nasal cannula was on 4 liters per minute. The oxygen should have been set at 3 liters per minute according to the physician order. During an interview on 1/5/24 at 3:05 p.m., the DON indicated oxygen therapy should have been administered according to the physician orders. A current, undated, facility document, titled "Oxygen Concentrator," provided by the DON on 1/5/24 at 4:13 p.m., indicated the following:		recur; All Nursing staff were in-serviced by the DNS/Designee on oxygen therapy, flow rates per order by 1/9/24. All new orders will be reviewed daily during our clinical meeting. The IDT will complete weekly checks that oxygen is being administered per order. 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; Ongoing compliance with this corrective action will be monitored via facility QAPI Program, with meetings held per facility schedule, and is overseen by the Executive Director. The Oxygen Therapy CQI audit tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	"...Purpose...To provide Oxygen for therapeutic use by utilizing a concentrator that converts ambient air to a higher concentration level of oxygen... Procedure 1) Verify and understand the physician's order. 2) Know the flow rate and duration of use... 9) Adjust the flow meter control knob to the flow setting prescribed by the physician. The graduated line of the meter should be aligned with the center of the floating ball...." 3.1-47(a)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and 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,			

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

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies regarding storage and maintenance of respiratory equipment for 1 of 7 residents reviewed for infection control. (Resident 22) Finding includes: During an observation on 1/3/23 at 3:26 p.m., Resident 22 was in bed in her room. Her oxygen was on via nasal cannula. The nasal cannula oxygen tubing was dated 12/24/23. The Trilogy (non-invasive mechanical ventilator) mask was not in use and was directly against the Trilogy machine on the right side of the bed. During an interview at the time of observation, the resident indicated she was unable to ambulate and both the oxygen concentrator and the Trilogy machine were not within reach. She relied on staff to manage her respiratory equipment. The resident had never seen staff use a barrier or bag for the Trilogy mask when they removed it from her face. During an observation on 1/4/23 at 8:09 a.m., the resident was in bed with her oxygen on via nasal cannula. The oxygen tubing date remained unchanged from the previous day. The Trilogy mask rested directly against the Trilogy machine on the side of the mask that fits against the residents face when worn. The resident indicated staff had just removed her Trilogy mask and placed it on the Trilogy machine in the corner . Resident 22's clinical record was reviewed on 1/4/24 at 11:35 a.m. Diagnoses included chronic	F 0880	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22's O2 tubing was replaced and the Trilogy mask placed in a bag immediately upon being informed of the issue. 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; . All residents requiring the use of respiratory equipment have the potential to be affected. An Audit was completed by the DNS on 1/22/24 to identify all residents that require respiratory equipment. All staff were in-serviced by the DNS/Designee on infection control practices and for storage and maintenance of respiratory	01/29/2024

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	obstructive pulmonary disease (COPD), shortness of breath, multiple sclerosis, and generalized muscle weakness. An order, dated 1/26/22, indicated Trilogy on at bedtime and off upon waking with oxygen at 4 liters per minute. An order, dated 11/22/22, indicated oxygen at 3 liters per minute worn daily via nasal cannula. An order, dated 12/17/21, indicated oxygen tubing and humidity were to be changed once a day on Sundays. An annual Minimum Data Set assessment, dated 11/9/23, indicated the resident was cognitively intact. She was dependent for toileting, personal hygiene, and lower body dressing. Special treatments included oxygen therapy and a non-invasive mechanical ventilator. A current care plan, revised 12/27/23, indicated the resident was at risk for impaired gas exchange related to COPD with shortness of breath. Interventions included administer oxygen as ordered (11/16/21) and Trilogy machine for sleep apnea (3/1/23). During an observation on 1/5/24 at 9:18 a.m., the resident was in bed with oxygen on at 4 liters per minute via nasal cannula. The nasal cannula oxygen tubing remained dated 12/24/23. The Trilogy mask was not in use and rested directly against the contaminated surface of the Trilogy Machine on the side that rests against the face when worn. A barrier was not in use, and it was not in reach of the resident. The resident indicated staff had removed her mask for her that morning and placed it on the Trilogy machine in		equipment. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-serviced by DNS/Designee on infection control practices and for the storage and maintenance of respiratory equipment. Assigned Nursing IDT team members will round daily to ensure storage of respiratory equipment is in accordance with infection control practices. 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; Ongoing compliance with corrective action will be monitored via scheduled facility QAPI meetings, and is overseen by the Executive Director. The Oxygen Therapy CQI audit will be completed weekly x 4 weeks, monthly x 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	the corner. During an interview at the time of observation on 1/5/24 at 2:54 p.m., LPN 2 indicated the resident's nasal cannula oxygen tubing was dated 12/24/23. Oxygen tubing should have been changed according to the order, every Sunday. The resident's Trilogy mask was placed directly on top of the Trilogy machine and should have been stored in a bag when it was not in use. During an interview on 1/5/24 at 3:05 p.m., the DON indicated oxygen tubing should have been changed every Sunday according to the physician orders. Trilogy masks and Continuous Positive Airway Pressure (CPAP) masks should have been stored in a bag when they were not in use. Improper storage and maintenance of respiratory equipment were potential risks for infection. During an interview on 1/5/24 at 4:14 p.m., the DON indicated the facility policy lacked information on how the respiratory equipment should be stored. A current facility policy, dated 3/2022, titled "Infection Prevention and Control Program Policy," provided by the facility following entrance conference on 1/2/24 at 1:50 p.m., indicated the following: "...POLICY: The facility shall establish and maintain infection prevention and control program [IPCP] designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections... GOALS: The goals of the infection prevention and control program are to: 1. Decrease the risk of infection to residents through investigation and surveillance... 5. Maintain compliance with state and federal regulations related to infection			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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	prevention and control...." 3.1-18(a)			