STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	12/15/2022

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WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 7, 8, 9, 12, 13, 14, & 15, 2022 Facility number: 011150 Provider number: 155760 AIM number: 200831020 Census Bed Type: SNF/NF: 22 SNF: 20 NF: 23 Residential: 91 Total: 156 Census Payor Type: Medicare: 20 Medicaid: 23 Other: 22 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 12/28/22.	F 0000	sup="">Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey ending December 15, 2022. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and records review the facility failed to provide timely physician notification of respiratory symptoms for 1 of 3 residents reviewed for respiratory care. (Resident 39) Finding includes: During an initial interview and observation on 12/8/202 at 9:09 A.M., Resident 39 indicated going to the bathroom causes shortness of breath. A productive cough was observed. Resident 39's roommate, indicated that Resident 39 has been coughing for the past 3 to 4 days, and was keeping her awake at night. On 12/08/2022 at 10:04 A.M., Resident 39 had a productive cough and signs and symptoms of shortness of breath. Resident 39 indicated she is short of breath with just walking from her recliner to the bathroom. During an observation on 12/08/2022 at 10:29 A.M., the therapy staff was observed in Resident 39's room. Resident 39 was coughing. The therapy staff was observed to inform Resident 39 to feel better as she refused therapy treatment. " ...You sound like you have a lot of stuff in there ...." On 12/9/2022 9:45 A.M., Resident 39 complained of coughing and shortness of breath. A clinical record review was completed on 12/9/2022 at 1:22 P.M. Diagnoses included, but were not limited to: pulmonary fibrosis, chronic obstructive pulmonary disease, centrilobular	F 0580	**1)** Resident 39 is still in the facility and was treated by the nurse practitioner for COPD exacerbation. Resident is currently doing well with no further concerns. 2) All residents on 300-hall had the potential to be affected. An audit was completed for residents on 300-hall to ensure MD was notified on any potential change in conditions. Nurses and the therapy department were in-serviced on change in condition policy and therapy was in-serviced on the importance of communication between departments. 3) DHS and/or designee will complete an audit on three resident charts to ensure MD notification was completed on change in conditions 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months.4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will	01/10/2023

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	emphysema, and paroxysmal atrial fibrillation. A 5-day Minimum Data Set (MDS) Assessment on 11/23/2022, indicated Resident 39 was cognitively intact and required oxygen use. A Skilled Nursing Assessment on 12/5/2022 indicated regular and unlabored respirations with clear lung sound and no cough. On 12/6/2022, a Skilled Nursing Assessment indicated shortness of breath with exertion, diminished breath sounds in both lobes, and cough present with thin mucous On 12/8/2022, the Assessment indicated shortness of breath with exertion, diminished breath sounds in both lobes, cough present with thin mucous, and a congested nose. On 12/9/2022, the Assessment indicated shortness of breath with exertion, diminished breath sounds in both lobes, cough present with thin mucous, and watery eyes. During an observation on 12/9/2022 at 1:57 P.M., a report conversation was observed. RN 4 was observed telling LPN 5, she " ...Wants NP [Nurse Practitioner] to see her as cough is getting worse, she's had a cold for a while ...." 12/12/22 " ... SOB [shortness of breath] with exertion, left side diminished with wheezes, right side clear, cough present with small amount thin mucous During an interview on 12/9/2022 at 1:35 P.M., the Program Director of Therapy indicated, no notes were available for the 12/8/2022 session. She indicated the documentation shows an "X" which		continue past 6 months if warranted until 100% compliance met.	

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	indicated not seen for therapy. She indicated the therapist would most likely inform the nurse the resident indicated was not feeling well. On 12/9/2022 at 2:10 P.M., Resident 39's roommate was observed coming to the area on the 300 hall and requested to find the office of Nurse Practitioner. "My roommate has been coughing for 3 days and 3 nights." A staff member immediately removed the resident from the area. During an interview on 12/9/0222 at 1:58 P.M., RN 4 indicated therapy was refused, but the therapist did not communicate the refusal. She indicated she had a cold awhile, and symptoms were worsening. She indicated a productive cough was noted two days ago. She indicated Resident 39 was on the nurse practitioner list to be seen today. RN 4 indicated a temperature had not been taken on Resident 39. RN 4 indicated, " ...She's always drinking all the time so it wouldn't be accurate ...." A Nurse's Note on 12/9/2022 at 2:00 P.M., indicated, " ...Resident has productive cough with thick yellow sputum. She has declined to participate in therapy and has had her meals in her room today...." A Nurse Practitioner's note on 12/9/2022 at 2:46 P.M. indicated, " ...Acute Visit ...Cough not feeling well .... Resident has been coughing for about 3-5 days, and it is not getting better. She has stopped participating in therapies, and is feeling worse. She does have the cough medicine, but she states it's not helping much. She does feel like she has to clear her throat multiple times a day. When she coughs, she coughs up clear liquid. She does have shortness of breath with exertion and it is getting worse. Denies any chest			

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	pain, heart palpitations ...Cough: tested for covid 19. it was negative. Will start Mucinex 600 mg po BID [twice daily] x [times] 10 days, Flonase 1 spray BID x 10 days, albuterol inhaler 2 puffs q4hrs[every 4 hours] prn [as needed] for shortness of breath/wheezing...." On 12/12/2022 at 12:57 P.M., Resident 39 indicated, " ...I'm doing better than I was ...." Resident stated she was still coughing and had shortness of breath, but her covid test was negative. She indicated what she coughs up is, " ...nasty ...." She offered a cup full of sputum filled tissues to observed. She indicated the new medication helps get the sputum coughed up. She indicated coughing wears her out and she can't walk and go anywhere even the bathroom, She indicated it feels like she's walked a mile to go to the bathroom. A current policy titled, "Notification of Change in Condition", was provided on 12/14/2022 at 9:46 A.M., by the Executive Director, and indicated, "...Purpose To ensure appropriate individuals are notified of change in condition. The facility informed the resident, consult with the resident's physician and if known the resident's legal representative ...." 3.1-5(a)(2)			
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			

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	resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the 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			

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	trauma-informed. Based on observation, record review, and interview, the facility failed to develop a person-centered care plan for 3 out of 23 residents whose care plans were reviewed (Residents 7, 41, and 46). Findings include: 1. During an interview on 12/07/2022 2:52 PM, Resident 7 indicated she had pain all over. The resident indicated pain medication was ordered but didn't work. A clinical record review on 12/09/2022 11:36 A.M., indicated Resident 7's diagnoses included, but were not limited to, unspecified sequelae of cerebral infarction and dorsalgia, unspecified. Physician's orders dated 11/14/2022 to 12/14/2022 indicated, but were not limited to, gabapentin 300 mg (milligram) for nerve pain, tizanidine 2 mg for muscle spasms, acetaminophen 325 mg for mild pain, biofreeze 4% menthol gel for chronic pain, aspercreme lidocaine 4% patch for pain, and oxycodone-acetaminophen 10-325 mg for pain. A Quarterly MDS (Minimum Data Set) Assessment dated 9/14/2022 included, but was not limited to, the following information: BIMS (Brief Interview for Mental Status) indicated a score of 13, which signifies intact cognition; extensive assist of 2 for transfers; extensive assist of 1 for dressing, personal hygiene, and toileting; routine and prn (as needed) pain meds; opioid use daily; and no special programs, hospice or dialysis.	F 0656	1) Residents 41 and 7 remain in the facility and resident 46 no longer resides in the facility. Resident care plans have been updated to reflect person-centered approaches. 2) Residents at risk for pain, behaviors, and/or depression and anxiety have the potential to be affected by the alleged deficiency. MDS coordinator will complete a review on all pain, behaviors, depression, and anxiety care plans to ensure care plans are resident centered. MDS coordinator and Social Service director were in-serviced on developing and implementing person centered care plans. 3) MDS coordinator and/or designee will audit pain, behaviors, and depression/anxiety care plans for three residents 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months. 4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	01/10/2023

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	During an interview on 12/12/2022 at 01:21 P.M., RN 3 indicated medications usually worked, but she had also tried warm compresses which also helped. Employee further indicated resident reported if meds do not work. The care plan problem for pain dated 4/21/2021 indicated, but were not limited to, the following interventions: observe for and record verbal and non-verbal signs of pain, reposition as needed, notify MD of increased pain, administer medications as ordered and notify MD for any side effects observed or lack of effectiveness, attempt non-pharmacological interventions. 2. During an interview on 12/7/2022 at 2:20 P.M., Resident 41 indicated she had some depression. A clinical record review on 12/12/2022 at 9:16 A.M., diagnoses included, but were not limited to, Parkinson's; dementia, unspecified, without behavioral disturbances; major depressive disorder, single episode; and anxiety disorder, unspecified. Physician's orders dated 11/14/2022 to 12/14/2022 indicated, but were not limited to, Ativan 0.5 mg; Namenda 10 mg; paroxetine20 mg; and trazodone 150 mg. A Quarterly MDS Assessment dated 11/25/2022 included, but was not limited to, the following: BIMS was 15, signifying intact cognition; no behaviors; supervision of 1 for all activities of daily living but set up for eating and bathing; received an antidepressant and antianxiety medication daily; and no special programs, treatments, or procedures. A care plan problem dated 8/11/2022 for anxiety		warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	and depression included, but were not limited to, the following interventions: assist her in making contact with family/friends as needed; allow resident to vent feelings and frustrations; encourage resident to attend structured activities of preference and participate in leisure/pastime activities; provide supportive counseling contacts as needed; meds per orders; observe mood, affect, and behaviors with all hands on care and contacts. During an observation on 12/12/2022 at 9:42 A.M., resident was sitting on side of bed, still in her pajamas, with breakfast tray 1/2 eaten. During an interview at the same time, the resident indicated it was good, but she was done now. Indicates she prefers to stay in her room and watch her TV rather than go to activities. During an interview on 12/12/2022 at 3:25 P.M., the Social Service Director indicated that she was new and needs to talk to staff some more to update care plans with person centered interventions. 12/13/2022 3:01 P.M. During an interview, the DON indicated the care were not person centered. 3. A clinical record review was completed on 12/12/2022 at 10:21 A.M. Resident 46's diagnoses included, but were not limited to: arthritis, Parkinson's disease, dementia, anxiety, depression, schizophrenia, psychosis and delusional disorder. An annual MDS (Minimum Data Set) Assessment, dated 7/16/2022, indicated Resident 46 was severely confused. Received antipsychotic, antianxiety and antidepressant medications, with a GDR (gradual dose reduction) on 2/11/2022.			

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	A current care plan, dated 8/5/2021, indicated Resident 46 demonstrated physically abusive and resistive behaviors towards staff during hands on care. The resident frequently refuses personal grooming assistance such as shaving, face washing, nail cleaning and changing soiled clothing. Interventions included, but were not limited to: Re-approach with a different staff member or at a different time. Approach resident in a calm and unhurried manor to deliver care and provide services. Explain care process prior to delivery of care as needed. Observe for signs of sensory over stimulation and encourage resident to move into less stimulating environment as needed. Offer choices in all hands on care and contacts. A current carte plan, dated 8/5/2021, indicated Resident 46 had inappropriate behaviors including: physical aggression, verbal aggression, barricading self in room, and isolation from others. Interventions included, but were not limited to: Approach resident in a calm and unhurried manor to deliver care and provide services. Assess for pain and follow pain management regiment when applicable. Assess for unmet needs such as need for toileting, rest, food, companionship, etc. Assist resident to away from other residents as needed. Determine cause for inappropriate behavior and refer to physician as needed for intervention. Encourage participation in structured activities as appropriate. Observe for triggers of inappropriate behaviors and alter environment as needed. The care plans lacked individualized person centered interventions to prevent further behaviors.			

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	During an interview, on 12/13/2022 at 3:01 P.M., the Director of Nursing indicated the care plans were not person centered for the behaviors. On 12/14/2022 at 10:00 A.M, the Administrator provided the policy titled, "Comprehensive Care Plan Guidelines", dated 5/22/2018, and indicated the policy was the one currently used by the facility. The policy indicated"... b. Care plan interventions should be reflective of the risk area(s) or disease processes that impact the individual resident. c. Should new identified areas of concern arise during the residents stay, they should be addressed on the care plan. d. iii. Interventions should be reflective of the individual's needs and risk influences as well as the resident's strengths. 2... Address problems that become ongoing or chronic with a new comprehensive care plan... The comprehensive care plan should be reviewed no less than quarterly with the completion of the OBRA assessment, and revised to reflect changes in the resident condition as they occur... 5. If the resident is readmitted to the campus, the previous care plan will be reviewed and updated to meet the resident's current needs. 6. Comprehensive care plans need to remain accurate and current...." 3.1-35(a)			
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			

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	comprehensive person-centered care plan, and the residents' choices. Based on record review and interview and observation, the facility failed to assess, and monitor a skin issue for 1 of 3 residents reviewed for skin issues, failed to follow physician orders for pressure ulcer prevention and continuous positive airway pressure (CPAP) equipment changes. (Residents 45, 218 & 9) Finding includes: 1.During an interview, on 12/7/2022 at 2:26 P.M., Resident 45 was observed with a large dark purple bruise to the inner aspect of her right upper arm. The resident indicated the bruise to her arm was from the staff pulling her up in bed. A clinical record review was completed, on 12/09/2022 at 9:30 A.M. Resident 45's diagnoses included, but were not limited to: fractured right femur, protein malnutrition, anxiety, and had a pacemaker. An Admission MDS (Minimum Data Set) Assessment, dated 11/13/2022, indicated Resident 45 was severely cognitive impaired. Required extensive assist of 2 staff for bed mobility, transfers, dressing, toilet use and limited assist for eating. A current care plan, dated 11/25/2022, indicated the resident was at risk for excessive bleeding and bruising related to medications. Interventions included notify physician of abnormal bruising and or bleeding. Skilled Documentation, dated 12/7/2022, indicated the resident had normal skin integrity and no skin issues.	F 0684	1) Resident 45 was immediately assessed by nurse and MD once notification was made with no concerns noted. Bruise is now healed. Resident 218 continues to be followed by wound nurse and MD. Resident air mattress was replaced. An order for resident was updated by MD per resident preference for heel protectors and is in place. A skin sweep was completed with no issues identified. Resident 9's equipment was replaced, and MD orders were obtained for cleaning. 2) Any resident with increased risk for bruising, with pressure injuries, and that have current orders for CPAP have the potential to be affected by alleged deficient practice. Nurses were in-serviced related to identifying skin alterations and opening events, following MD orders related to heel protectors and air mattresses, and following MD orders in relation to cleaning and replacing CPAP equipment. CNAs were in-serviced on reporting skin alterations to nurse once identified and were educated on encouraged to follow preventative skin measures. 3) DHS and/or designee will complete a visual skin	01/10/2023

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	Skilled Documentation, dated 12/8/2022, indicated the resident had normal skin integrity and no skin issues. Skilled Documentation, dated 12/9/2022, indicated the resident had normal skin integrity and no skin issues. A Nurses' Progress Note, dated 12/9/2022 at 10:57 A.M., indicated the aide and nurse were successful with assisting Resident 45 to change her gown, the bed clothes and receive a partial bed bath. Skilled Documentation, dated 12/11/2022, indicated the resident had normal skin integrity and no skin issues. During an interview, on 12/13/2022 at 11:42 A.M., RN 11 indicated she had seen the bruised area a couple weeks ago. RN 11 indicated if a resident had a new skin issue, the aide should tell the nurse about the area, the nurse should measure it and tell the wound nurse. During an interview, on 12/13/2022 at 1:58 P.M., C.N.A 14 indicated when they move the resident up in bed they will put the foot of the bed up, so gravity will help. We will use the lift sheet and then put our hands as close to the resident and lift her up. She indicated that they will at times lift her up in the wheel chair by her pants and around her arms, but she had not been of bed for awhile. A review of the Nursing progress notes, dated 12/1/2022 through 12/12/2022, lacked the documentation of the bruise, weekly measurements and a care plan for the new bruise.		assessment on 3 dependent residents for 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months. DHS and/or designee will audit 3 residents to ensure preventative skin interventions are in place and that air mattresses are functional for 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months. DHS and/or designee will audit all residents on CPAP's weekly to ensure proper cleaning and changing of equipment per order weekly x 6 weeks, every other week for 6 weeks, and monthly for 3 months. 4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	During an interview, on 12/14/2022 at 12:20 P.M., the Director of Nursing indicated she could not locate any documentation of the bruise. 2. During an observation on 12/08/2022 at 1:52 P.M., Resident 218 was laying in bed. The foot booties were on the floor at the end of the bed, and the low air loss mattress was set on standby. On 12/9/2022 at 8:56 A.M., Resident 218 was in the common area in her wheelchair, and had non-skid socks on her feet. On 12/9/2022 at 9:32 A.M., the foot booties were observed laying on the floor at the end of the bed. On 12/9/2022 at 10:04 A.M., the low air loss mattress was observed to be on standby. A clinical record review was completed on 12/9/2022 at 10:05 A.M. Diagnoses included, but were not limited to: anemia, pressure ulcer of sacral region, and type 2 diabetes mellitus. A 5-day Minimum Data Set (MDS) Assessment on 11/22/2022, indicated Resident 218 was severely cognitively impaired. She required extensive assistant with one staff member for bed mobility and toileting. She required extensive assistance with two or more staff members for transferring. She was at risk for developing pressure ulcers and was admitted with a stage 4 pressure ulcer to the sacrum. A Physician's Order on 9/9/2022, indicated, " ... Low Air Loss Pressure Reducing Mattress in place & functioning properly ...Three Times A Day ...." A Nurse's Note on 12/5/2022 at 1:52 P.M.,			

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	indicated, " ...This writer notified by staff that resident has a "red" area to R [right] heel. Writer in to assess and finds R heel is red and blanchable. MD made aware and gave N/O [new order] skin prep to bilateral heels BID [twice daily] and protective boots at all times ...." On 12/5/2022, a Physician's Order indicated, " ...Protective Boots BLE [bilateral lower extremities] at All Times Special Instructions: preventative Three Times A Day ...." and " ...Skin Prep to Bilateral Heel BID [twice daily] Special Instructions: preventative Twice a Day ...." During on observation on 12/12/2022 at 9:08 A.M., Resident 218 was observed sitting in her room in a wheelchair eating breakfast. Her feet were resting on foot pedals with no foot booties in place. On 12/12/2022 at 3:29 P.M., Resident 218 was observed lying in bed sleeping with blue non-skid socks on her feet. Her heels were not floated. The low air loss mattress is not turned on with no noted illuminated lights observed. On 12/13/2022 at 10:19 A.M., Resident 218 was observed sitting in her wheelchair in an activity. She did not have foot booties on her feet. On 12/13/2022 at 10:44 A.M., Resident 218 was observed lying in bed. The low air loss mattress had no illuminated lights and was not functioning, and her foot booties are not on feet. On 12/13/2022 at 1:33 P.M., Resident 218 was observed lying in bed. The low air loss mattress has no illuminated lights and was not turned functioning, and her foot booties are not on feet. During an observation and interview on			

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	12/13/2022 at 1:37 P.M., 2 indicated the low air loss mattress did not have any illuminated lights. During an interview on 12/13/22 at 1:37 P.M., RN 3 indicated the physician order will indicate the pressure setting for the low air loss mattress. She indicated the settings had not changed recently. She indicated that foot booties are not needed with a low air loss mattress. RN 3 indicated physician orders should be followed. She observed the low air loss mattress and indicated the low air loss mattress was not turned on. She indicated when the mattress is on standby it is on hold and not inflating. During an observation on 12/14/2022 at 10:48 A.M., the heels were observed. RN 2 indicated a diabetic pressure ulcer was found this morning, and examined by the physician. Resident 218 had her foot booties on, and the low air pressure mattress was illuminated to indicate power. RN 2 indicated a diabetic ulcer to the right heel was found this morning. She described a left medial area filled blister with dried eschar callus like tissue to the ball of the heel. 3. During an initial interview on 12/08/2022 at 1:46 P.M., Resident 9 and his wife indicated the CPAP machine does not receive routine sanitation and equipment changes. A clinical record review was completed on 12/12/2022 at 10:55 A.M. Diagnoses included, but were not limited to: chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease, obstructive sleep apnea and pulmonary fibrosis. An Annual Minimum Data Set (MDS) Assessment on 11/22/2022, indicated Resident 9			

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	was cognitively intact and required oxygen use. On 11/14/2022, the Sleep and Allergy Medicine Nurse Practitioner provided an order for full face mask change every 6 months, a headgear change every 6 months, tubing change every 3 months, a non-disposable filter change every 6 months and a disposable filter change every month. A care plan on 8/19/2016 and reviewed on 11/29/2022, indicated, " ...Resident has sleep apneas and has been prescribed a CPAP machine to reduce respiratory distress while sleeping. He sometimes refuses to wear CPAP ...." On 12/12/2022 at 3:44 P.M., an observation of the CPAP equipment was observed, A small amount of debris to full face mask, and soilage to headgear was observed. During an interview on 12/13/2022 at 11:11 AM, RN 4 indicated the CPAP cleaning is scheduled by the night shift staff once a week, and Resident 9 should have a physician order to complete this task. RN 4 indicated she was not aware of how the changing of equipment happens due to this task is a night shift duty and this task should have an order to change the equipment. RN 4 indicated she doesn't think the mask gets changed out that much. RN 4 reviewed the Physician's Order record and identified the settings of the CPAP. She indicated she did not see the orders for sanitation of the CPAP equipment or changing the CPAP equipment. RN 4 reviewed the discontinued orders and could not find any orders for sanitation of the CPAP equipment or changing the CPAP equipment. On 12/14/2022 at 12:20 P.M., the Director of Nursing provided the policy titled, "Guidelines for			

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	Weekly Skin Observations", dated 1/7/2019, and indicated the policy was the one currently used by the facility. The policy indicated"...The monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures indicated. 1. A full body observation shall be completed weekly by the licensed nurse. ...6. IN addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified...." A policy for CPAP use and cleaning was request on 12/13/2022 at 2:00 P.M. The Executive Director indicated on 12/14/2022 at 9:46 A.M. a policy was not available. A policy titled, "Notification of Change in Condition" ,was provided on 12/14/2022 at 9:46 A.M. by the Executive Director, and indicated, "Purpose to ensure appropriate individuals are notified of change in condition. The facility informed the resident, consult with the resident's physician and if known the resident's legal representative ... A policy titled, "Pressure/Stasis/Arterial/Diabetic/Wound Guidelines", did not show indications of wound prevention. 3.1-5(a)(2) 3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 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 interview, observation, and record review the facility failed to provide equipment (tubing, filter, mask and water chamber) replacements and routine sanitation of a continuous positive airway pressure (CPAP) machine for 13 residents reviewed for respiratory care. (Resident 9) Finding includes: During an initial interview on 12/08/2022 at 1:46 P.M., Resident 9 and his wife indicated the CPAP machine does not receive routine sanitation and equipment changes. A clinical record review was completed on 12/12/2022 at 10:55 A.M. Diagnoses included, but were not limited to: chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease, obstructive sleep apnea and pulmonary fibrosis. An Annual Minimum Data Set (MDS) Assessment on 11/22/2022, indicated Resident 9 was cognitively intact and required oxygen use. A Physician's Order on 10/30/2022, indicated, " ...Auto CPAP set at Min [minimum] pressure 3 Max [maximum] pressure 14 with oxygen at 2 liters during NOC [night] and as needed during day	F 0695	1) Resident 9 remains in the facility. Facility provided a CPAP for resident until resident spouse is able procure a replacement. 2) Any resident who currently has orders for use of a CPAP machine has the potential to be affected. Nurses were in-serviced on communicating with DHS or a nurse manager when resident's personal equipment is not functional. DHS completed an audit of all residents with CPAP machines in house to ensure proper functioning.3) DHS and/or designee will complete weekly audits for 6 weeks, every other week for 6 weeks and monthly for 3 months.4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will	01/10/2023

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	...Special Instructions: Chart refusal to wear CPAP Once a Day ...." On 11/14/2022, the Sleep and Allergy Medicine Nurse Practitioner provided an order for full face mask change every 6 months, a headgear change every 6 months, tubing change every 3 months, a non-disposable filter change every 6 months and a disposable filter change every month. A Nurse's Note on 11/14/2022 at 3:08 P.M., indicated, " ...Spoke with this resident's wife. She states the NP [Nurse Practitioner] at [name of the Sleep and Allergy Clinic] states [resident's name] needs a new CPAP machine. She states he tells her, it's not working and she received notice that it has been recalled. NP states he is only using it 20% of the time. This RN [Registered Nurse] reminded her he often refuses, when it is offered ...This resident's wife is going to start the process of getting a new machine through the Sleep Clinic ...." A care plan on 8/19/2016 and reviewed on 11/29/2022, indicated, " ...Resident has sleep apneas and has been prescribed a CPAP machine to reduce respiratory distress while sleeping. He sometimes refuses to wear CPAP ...." On 12/12/2022 at 3:44 P.M., an observation of the C -PAP equipment was observed, A small amount of debris to full face mask, and soilage to headgear was observed. During an interview on 12/13/2022 at 11:11 AM, RN 4 indicated the CPAP cleaning is scheduled by the night shift staff once a week, and Resident 9 should have a physician order to complete this task. RN 4 indicated she was not aware of how the changing of equipment happens due to this		continue past 6 months if warranted until 100% compliance met.	

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	task is a night shift duty and this task should have an order to change the equipment. RN 4 indicated she doesn't think the mask gets changed out that much. RN 4 reviewed the Physician's Order record and identified the settings of the CPAP. She indicated she did not see the orders for sanitation of the CPAP equipment or changing the CPAP equipment. RN 4 reviewed the discontinued orders and could not find any orders for sanitation of the CPAP equipment or changing the CPAP equipment. A policy for CPAP use and cleaning was request on 12/13/2022 at 2:00 P.M. The Executive Director indicated on 12/14/2022 at 9:46 A.M. a policy was not available. 3.1-18(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review, observation and interview, the facility failed to complete an AIMS assessment timely and failed to have adequate justification for the increase of an antipsychotic medication in 1 of 5 residents reviewed for unnecessary medications. (Resident 46) Finding includes: A clinical record review was completed on 12/12/2022 at 10:21 A.M. Resident 46's diagnoses	F 0758	1) Resident 46 no longer resides at the facility. Prior to discharge, the AIMS assessment was completed with no concerns noted. Due to resident no longer being at facility, no med adjustments were completed, and no behaviors noted.2) All residents on prescribed psychotropic medications had the	01/10/2023

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	included, but were not limited to: Parkinson's disease, dementia, anxiety, depression,delusional disorder and schizophrenia. An annual MDS (Minimum Data Set) assessment, dated 7/16/2022, indicated the resident was severely confused, received antipsychotic, antidepressant and antianxiety medications. A GDR (gradual dose reduction) was completed on 2/11/2022. A Physician order, dated 7/26/2021, indicated to complete AIMS (Abnormal Involuntary Movement Scale) assessment every 3 months on the 1st of every 3rd month. AIMS assessments had been completed on 1/1/022 and 4/1/2022. There were no completed AIMS assessments for 7/2022 and 10/2022. During an interview, on 12/13/2022 at 10:41 A.M., the Director of Nursing indicated the resident should have had the AIMS completed in July and October. A current care plan, dated 12/8/2022, indicated: Resident presents with a diagnosis of vascular dementia with behavioral disturbances, schizoaffective disorder, Mood disorder, psychosis,delusional disorder is treated with anti-psychotic medication. Interventions included, but were not limited to: Monitor for adverse side effects of medication. Observe mood, affect, and behaviors with all hands on care and contacts. A Physician's order, dated 2/11/2022, indicated Resident 46 received Zyprexia 1.25 mg (milligrams) daily.		potential to be affected by alleged deficiency. An audit was completed for all residents with psychotropic medications to ensure all AIMS assessments were in compliance with no concerns noted. Inservice education was completed with admissions nurse, the social service director and floor nurses related to AIMS policy, psychotropic medication usage and GDR's. 3) DHS and/or designee will complete an audit on all residents who are prescribed psychotropic medications to ensure AIMS is completed 1x monthly for 6 months. Social Service Director and/or designee will complete an audit on all resident that have had an increase in their psychotropic medications to ensure proper documentation is in place monthly for 6 months. 4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A Psychiatry Progress note, dated 8/3/2022 indicated the Nurse Practitioner had been asked to see the resident due to concerns of dementia, depression disorder, delusions, and mood and anxiety disorders. Psychiatric: anxiety and depression checked. The patient was referred for the management of depression, anxiety, and delusions. Patient reported to have hallucinations, be delusional and combative. Comments regarding medication: patient on multiple psychotropic medications. Tolerating medications with out any reported side effects. Will continue medications. Changes in medications were explained to patient, including purpose, dosage, directions, side effects, risks, benefits and options. Plan continue current medications, A Miscellaneous Note from the psychiatric provider,dated 8/10/2022, indicated a report from SS (Social Service) and nursing regarding mood/behavior concerns about the patient. Patient with progressing episodes of delusions/paranoia. Patient reported to have increasing episodes of more restlessness, he believes staff are trying to poison him. Irritability and increasingly difficult to redirect, interventions and redirection by staff usually not successful. Will increase Zyprexa to 2.5 mg daily. The Behavior documentation dated 8/1/2022 through 8/10/2022 indicated: no behaviors of grabbing others, wandering, hallucination, delusions and or combative were documented on 8/1/2022, 8/2/2022, 8/3/2022, 8/4/2022, 8/5/2022, 8/6/2022, 8/7/2022, and on 8/8/2022. Review of Nurses Notes, dated 8/1/2022 through 8/11/2022, lacked the documentation to show the resident had an increase in any behaviors.			

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	155760	A. BUILDING 00 B. WING	12/15/2022

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	On 12/14/2022 at 3:01 P.M., the Director of Nursing indicated she could not provide documentation of increased behaviors and the medication should not have been increased. On 12/14/2022 at 10:15 A.M., the Administrator provided the policy titled," Psychotropic Medication Usage and Gradual Dose Reductions", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage...." On 12/14/2022 at 10:15 A.M., the Administrator provided the policy titled,"Guidelines for Mental Health Wellness Program", dated 12/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated...6. Nursing staff shall document new or exacerbated behaviors on the 24 hours report(facility Activity Report) and nursing progress notes... 12. In the event a behavior potentially may need lead to harm to the resident or others and expanded summary should be documented in the nursing notes with follow up reflected as soon as possible in the social service notes and residents profile updated to communicate to caregivers what is included on the behavior plan...." 3.1-48(a)(3) 3.1-48(a)(4)			

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F 0812 SS=E 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 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 observations and interviews the facility failed to provide a sanitary refrigerator and storage for the residents' nutrition needs in 3 out of 3 unit nutrition pantries that were observed. Finding includes: During an observation of the 100-unit nutrition pantry with the Dietary Manager, on 12/13/2022 at 1:20 P.M., the refrigerator had ice buildup in the freezer compartment. The 200-unit refrigerator had spills on door shelves and the freezer had ice buildup that was discolored brown. The floor in the nutrition pantry	F 0812	1) No residents were affected by the alleged deficiency. The Director of Food Services defrosted and cleaned all fridge units and removed nonfood items from the drawer. 2) All residents had the potential to be affected, but no residents had complaints related to the alleged deficiency. The freezers were immediately defrosted, cleaned, and returned to units. In-services were	01/10/2023

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	had brown spills. The 300-unit refrigerator had spills noted on the bottom shelf and ice buildup in the freezer. The microwave had brown food particles on the bottom and the walls. Nail clippers and nail files were noted in the drawer with creamers and condiment packets. During an interview on 12/13/2022 at 1:34 P.M., RN 3 indicated nail care items should not be kept with food. During an interview on 12/13/2022 at 1:35 P.M., the Dietary Manager indicated there should not be ice buildup on the freezers. He also indicated he did not know the freezers in those refrigerators were supposed to be defrosted. 12/15/2022 at 10 A.M., the DON indicated they do not have a policy for cleaning and defrosting refrigerators in the nutrition pantries. 3.1-21(i)(3)		completed for all culinary staff on storage of nonfood and identifying ice buildup. 3) DFS and/or designee will complete an audit to ensure that nonfood items are not in pantry storage and that all freezers do not have ice buildup for 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months. 4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 15, 2022 Facility number: 011150	R 0000	sup="">Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The	

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	Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 12/28/22.		plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey ending December 15, 2022. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to provide sanitary food service to 12 of 26 residents observed for food delivery service. Finding includes: During an observation on 12/15/2022 at 11:37 A.M., dining room food service was observed in the main dining room. Employee 9 was observed to have his thumb beyond the rim of the plate when serving the residents main plate. During an observation on 12/15/2022 at 11:43 A.M., dining room food service was observed in the main dining room. Employee 9 was observed to have his thumb beyond the rim of the plate when serving the residents main plate. During an interview on 12/15/2022 at 11:51 A.M., Employee 9 indicated his thumb should not be	R 0273	1) No residents were affected by alleged deficiency. The Director of Food Services immediately educated staff on proper food handling. 2) All residents had the potential to be affected by alleged deficiency. The Director of Food Services completed an in-service with all culinary staff of proper food handling and delivery.3) The Director of Food Services and/or designee will complete visual audits on meal handling and delivery for 3x's per week for 4 weeks, then weekly for 4 weeks, then every other week for 4 weeks, the monthly for 3 months. 4) As a quality measure, the DHS or designee will review any findings	01/10/2023

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	over the edge of the plate being served. On 12/15/2022 at 2:20 P.M., the Administrator provided a policy entitled, "Assisted living Dining Services Guideline". dated 12/2011, and indicated the policy was the one currently used by the facility. The policy indicated",,,13. ...The campus shall ensure food is procured, stored, prepared and distributed in a manner that protects it against contamination and spoilage...."		and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure that all required resident information was located in the facility emergency binder for 90 of 90 Residents whose emergency files were reviewed.	R 0356	1) No residents were affected by alleged deficiency. Emergency Information binder was updated immediately with no adverse effects noted with any resident	01/10/2023

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	Finding includes: On 12/15/2022 at 1:35 P.M., the emergency binder was reviewed and indicated that 90 of 90 residents residing in the facility lacked advanced directive documentation. During an interview, on 12/15/2022 at 2:01 P.M., the Director of Nursing indicated the facility was unaware of the policy. On 12/15/2022 at 2:17 P.M., the Administrator provided the policy titled, "Assisted Living Admission Agreement Guidelines", dated 11/2011, and indicated the policy was the one currently used by the facility. The policy indicated"...5.C....The facility's policy regarding advanced directives and an explanation of the rights of the resident under state law concerning advanced directives...."		related to alleged deficient practice. Administrator reviewed and corrected all emergency file information for residents.2) Residents in the Assisted Living have the potential to be affected by alleged deficiency. 100% audit completed and resident's emergency files have been updated appropriately. Education completed with the Customer Service Representative regarding AL emergency file guidelines. Education also completed with Director of Assisted Living on updating AL emergency book upon any advance directive change.3) As a measure of ongoing compliance, the Administrator and/or designee will audit 5 resident emergency information files in the binder weekly for 4 weeks, then twice monthly for 2 months, then monthly for 3 months to ensure resident information is updated appropriately. 4) As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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