STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00436651, IN00436931, and IN00437009. Complaint IN00436651 - No deficiencies related to the allegations are cited. Complaint IN00436931 - Federal/State deficiencies related to the allegations are cited at F656. Complaint IN00437009 - No deficiencies related to the allegations are cited. Survey dates: July 2, 2024 Facility number: 000175 Provider number: 155275 AIM number: 100274440 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 1 Medicaid: 48 Other: 7 Total: 56 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 3, 2024.	F 0000	We are requesting a desk review.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility	F 0656	b="">Facility is respectfully	07/18/2024

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

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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	failed to develop care plans for 1 of 3 residents reviewed for wounds. A care plan was not developed after a resident returned from the hospital with a new diagnosis and new medication order. (Resident M) Finding includes: On 7/2/24 at 10:19 A.M., Resident M's clinical record was reviewed. Diagnosis included, but was not limited to, cellulitis of the right lower limb, dated 5/22/24. The most current Admission MDS (Minimum Data Set) Assessment, dated 4/24/24, indicated Resident M had moderate cognitive impairment, required partial to moderate assistance (staff does less than half) for sit to stand transfers and toileting, was at risk for pressure ulcers, and had no ulcers, wounds, or skin issues. The facility census indicated Resident M was discharged to the hospital on 5/20/24 and returned to the facility on 5/22/24. Hospital discharge papers, dated 5/22/24, indicated Resident M was discharged to the facility with a new diagnosis of cellulitis of right lower extremity and had new orders for clindamycin (an antibiotic) 300 mg (milligrams) by mouth three times a day for 7 days. The clinical record lacked a care plan for the new diagnosis of cellulitis and the newly prescribed antibiotic. On 7/2/24 at 3:35 P.M., the MDS Coordinator indicated a new diagnosis or medication got added to the care plan upon admission or re-admission to the facility.		requesting paper compliance for all deficiencies in this POC. **Tag# 656 Care Plans** **It is the policy of this facility to develop care plans for wounds and update care plans after a resident returns from the hospital with a new diagnosis and a new medication.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident M no longer resides at the facility.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** The MDS/Designee completed a 90 day look back of residents that return to the facility from the hospital for new diagnoses and new medications and updated the care plans as needed 7-9-2024. The DON/Designee completed an audit of residents with wounds and care plans were updated as needed 7-8-2024. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** **The ADM/Designee in-serviced the MDS and DON on reviewing re-admissions for new**	

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	On 7/2/24 at 3:55 P.M., the Administrator provided a current Baseline Care Plan Assessment/Comprehensive Care Plans policy, revised 3/23/21, that indicated "The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning/CQI [continuous quality improvement] meetings where in-depth review of the 24 Hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary". This citation relates to Complaint IN00436931 3.1-35(a)		**diagnoses and new medications and updating care plans on 7-3-2024. Additionally, if any staff is not compliant with points in the in-service will be further educated/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:** **The DON/Designee will audit re-admissions from the hospital 5 times a week x 4 weeks for new medications, new diagnosis, care plan updated, then 3 times a week x 4 weeks, then once a month x 4 months.** If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic changes for each deficiency will be completed:**	

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			DOC: 7-18-2024	