STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

(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 IN00440342 and IN00443034. Complaint IN00440342 - Federal/State deficiencies related to the allegations are cited at F686, F698, and F842. Complaint IN00443034 - Federal/State deficiencies related to the allegations are cited at F686, F693, F842, and F880. Survey dates: October 28 & 29, 2024 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 8 Medicaid: 33 Other: 6 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/4/24.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully requests paper compliance Thank you for your consideration, Respectfully, Kevin Mehay HFA Waters of Hobart 317.525.3537	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and	F 0686	**Waters of Hobart**	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Mehay	Executive Director	11/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: During an observation on 10/28/24 at 9:34 a.m., CNA 1 and QMA 2 were providing morning care to Resident F. The resident was turned to the right side and an uncovered pressure area was observed to the right side of the sacral area. The area had depth and was approximately 3 centimeters (cm) by 2 cm in size. There was no observed drainage. CNA 1 indicated she had not received the information in morning report at 6:30 a.m. that the dressing was off. She indicated the night staff had reported they last completed rounds around 5 a.m. CNA 1 left the room to report the dressing was not in place to the nurse. During an observation on 10/28/24 at 10 a.m., LPN 1 entered the room. He indicated he had not been informed by the night nurse during the shift report that the dressing was off the pressure area. The wound was then washed with wound wash and patted dried. The gloves were changed and then collagen was placed inside the wound wound and it was covered with calcium alginate and a border gauze. LPN 1 then dated the dressing. Zinc oxide was not applied during the treatment. Resident F's record was reviewed on 10/29/24 at 1:14 p.m. The diagnoses included, but were not limited to, stroke and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 9/5/24, indicated the cognition status was not		F686 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 10-31-24. Facility is respectfully requesting paper compliance for all deficiencies in this POC. **F686 Treatment/services to prevent/heal pressure ulcers** It is the policy of this facility to ensure residents with pressure ulcers receive the necessary treatment and services to promote healing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The DON/Designee assessed resident F and no negative outcome related to the alleged cited practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	

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	completed due to the resident unable to answer, there were no behaviors, dependent for all activities of daily living, always incontinent of bowel and bladder, and had one stage three (full thickness skin loss) pressure area. A Care Plan, dated 10/20/24, indicated a pressure wound to the right buttocks. The interventions included, the treatment would be completed as ordered. A Skin/Wound Progress Note, dated 9/8/24 at 8:32 p.m., indicated a stage three pressure area had been found on the right buttock. The measurement was 2.5 cm by 1.1 cm with a depth of 0.1 cm. A Physician's Order, dated 9/9/24, indicated the wound was to be cleansed, collagen was to be applied and the area was to be covered, daily on evening shift and as needed. A Physician's Order, dated 10/3/24, indicated a new treatment for the right buttock wound. The area was to be cleansed, patted dry, and medical grade honey was to be placed into the wound. Calcium alginate was to be applied and the area covered with a foam dressing every evening and as needed. The order was discontinued on 10/20/24. A Wound Nurse Practitioner Progress Note, indicated on 10/4/24, the wound was improving without complications. There was 30% of slough covering the wound. The peri-wound was intact, fragile, and macerated. A treatment of collagen in the wound, covered by calcium alginate and then border foam was to be completed daily. The Wound Nurse Practitioner's treatment order		The DON/Designee completed an audit of Wound Nurse Practitioners notes and verified correct treatment in place for residents with pressure ulcers on 10-31-24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff on completing treatments as ordered on DATE. The DON/Designee in-serviced the wound nurse on reviewing the wound nurse practitioners notes and updating treatment orders as needed on 10-31-24. Additionally, any staff member that fails to comply with the points of these in-services will be further educated and/or disciplined. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** The DON/Designee will audit wound nurse practitioners notes weekly and verify correct treatment order in place x 6 months. The DON/Designee will audit treatments on residents with pressure ulcer for correct treatment in place five times a week x 4 weeks, then 3 times a	

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	had not been transcribed on 10/4/24 and the treatment of the medical grade honey to the wound continued. A Physician's Order, dated 10/12/24, indicated zinc oxide paste was to be applied to the peri-wound daily with the pressure wound treatment. A Physician's Order, dated 10/20/24, indicated the right buttock pressure area was to be cleansed, patted dry, collagen was to be applied in the wound then covered with calcium alginate and a border gauze daily on evening shift and as needed. A Wound Nurse Practitioner Progress Note, dated 10/24/24, indicated the wound was stable with 10% slough. The peri-wound remained fragile, macerated, and now excoriated. There was a moderate amount of serosanguinal drainage. The daily treatment orders were changed to cleanse the wound, apply collagen in the wound, cover with calcium alginate and a border gauze. Zinc oxide was to be used on the peri-wound daily. During an interview on 10/29/24 at 2:27 p.m., the Corporate Regional RN indicated the Wound Nurse at the facility documented the information from the Wound Nurse Practitioner. She acknowledged the treatment orders were different than the Nurse Practitioner's orders. During an interview on 10/29/24 at 2:51 p.m., the Corporate Regional RN indicated there was no documentation that indicated why the medical grade honey had been ordered for the right buttock wound and acknowledged the treatment had not been changed when ordered by the Wound Nurse Practitioner on 10/4/24. The treatment order had not been changed until		week x 4 weeks, then 3 times a month x 4 months. If the facility is within 95% compliance at the end of the 6 months; 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 needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **Date Of Completion: 10-31-2024**	

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	10/20/24. The facility's skin/wound policy, dated 10/9/23, and received from the Minimum Data Nurse as current, indicated, the Physician/Nurse Practitioner was to be notified for orders for treatment for the wound and the orders were to be entered into the medical record and treatment and medication record as they are received. The orders were to be documented in the progress notes. Upon receipt of the order, immediate transcription of the order onto the Medication/Treatment Administration Record was to be completed and the treatment was to be initiated. This citation relates to Complaints IN00440342 and IN00443034. 3.1-40(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on record review and interview, the facility failed to ensure appropriate treatment and services were provided to residents with feeding tubes, related to physician's orders not followed when checking for proper placement of the feeding tubes, for 2 of 3 residents reviewed for feeding tube care. (Residents B and E) Findings include: 1) Resident B's closed record was reviewed on 10/28/24 at 1:06 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 9/14/24, indicated a severely impaired cognitive status, a feeding tube was	F 0693	**Waters of Hobart** **F693** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F693 Tube Feeding Mgmt/Restore Eating Skills** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.**	10/31/2024

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	present and supplied 51% or more of nutrition and 501 cubic centimeters (cc) or more of fluids daily. A Physician's Order, dated 6/7/24, indicated the feeding tube placement was to be checked for placement and the residual was to be documented prior to the administration of medications, formula, and flushing. A Care Plan, dated 6/13/24, indicated a feeding tube was required. The interventions included, the tube would be checked for placement and gastric contents/residual volume would be recorded. The Medication Administration Records (MARs), dated 8/2024 and 9/2024, indicated the placement of the feeding tube was to be checked prior to the administration of medications, formula, and flushing, and the residual was to be documented. The placement check was scheduled for days, evening, and nights. The amount of residual after each check had not been documented. 2) Resident E's record was reviewed on 10/29/24 at 10:58 a.m. The diagnoses included, but were not limited to, severe protein deficiency. An Admission MDS assessment, dated 9/15/24, indicated a moderately impaired cognitive status, a feeding tube was present and supplied 51% or more of nutrition and 501 cubic centimeters (cc) or more of fluids daily. A Physician's Order, dated 9/17/24, indicated the feeding tube was to be checked for placement prior to the administration of medications, formula and flushing. The amount of residual was to be documented.		Resident B no longer resides at the facility. Resident E was assessed by the RNC/Designee on 010/28/2024, no negative outcome related treatment and services provided to resident with feeding tubes. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed an audit of all residents with feeding tubes to ensure appropriate treatments and services are correctly provided, Physician Orders are followed, and Care Plans are updated. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on 10/30/2024 on following. 1 Following a physician's orders 2 Enteral Feeding policy 3 Care plans for enteral feeding. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:**	

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	A Care Plan, dated 10/9/24, indicated a feeding tube was present. The interventions indicated the feeding tube was to be monitored for proper placement/gastric residual. The Medication Administration Records (MARs), dated 9/2024 and 10/2024, indicated the placement of the feeding tube was to be checked prior to the administration of medications, formula, and flushing and the residual was to be documented. The placement check was scheduled for days, evening, and nights. The amount of residual after each check had not been documented. During an interview on 10/29/24 at 1:46 p.m., The Corporate Regional RN, indicated the amount of residual had not been documented on the MARs. A facility policy for enteral feedings, dated 7/3/2023 and received from the Minimum Data Set (MDS) Nurse as current, indicated the feeding tube would be assessed every eight hours and as needed. Placement of the tube in the stomach would be completed by observing for a change in the enteral tube length during feedings. If there is a change in length, aspiration of gastric contents may be used for placement evaluation. This citation relates to Complaint IN00443034. 3.1-44(a)(2)		DON/designee will audit residents receiving enteral feeding for appropriate treatment, physician orders, following policy and care plan weekly x's 4wks, then bi-weekly x's 8wks, and then monthly x's 3 months. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days. Date of Completion: 10-31-24	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on record review and interview, the facility failed to have ongoing communication with a resident's dialysis center, related to the facility not checking on a resident's location when they did	F 0698	**Waters of Hobart** **F698** **F698 Dialysis** It is the policy of this facility to	10/31/2024

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	not return from a dialysis appointment, for 1 of 2 residents reviewed for dialysis. (Resident C) Finding includes: Resident C's closed record was reviewed on 10/29/24 at 8:06 a.m. The diagnoses included, but were not limited to, end stage renal disease with dialysis, stroke, and dementia. An Modification of the Admission Minimum Data Set assessment, dated 6/17/24, indicated a severely impaired cognitive status, dependent on staff for all activities of daily living, and received dialysis. A Care Plan, dated 6/11/24, indicated dialysis was required. The interventions included, dialysis would be provided as scheduled. A Physician's Order, indicated dialysis was to be completed at a dialysis center on Monday, Wednesday, and Friday. A Nurse's Progress Note, dated 8/5/24 (Monday) at 4:39 p.m. and signed by LPN 3, indicated the medications were not administered due to the resident was discharged against medical advice. The next Nurse's Progress Note written, which was the last Nurse's Progress Note in the record, dated 8/6/24 at 7:29 a.m., indicated the medications were not administered due to the resident was discharged against medical advice. During an interview on 10/29/24 at 11:06 a.m., the Assistant Director of Nursing (ADON) indicated the resident had gone to the dialysis Facility on 8/5/24 and they must have sent her to the emergency room (ER). She had just reviewed the		ensure ongoing communication between facility and dialysis center and to document in the medical record reason resident is not returning from dialysis center to facility. **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Resident C no longer resides in the facility. **How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All resident that resides in the facility have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents in the facility. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?** The DON/Designee in-serviced the nursing staff on documentation in the EMR when a resident does not return from dialysis or an appointment any reason for not returning on 10-31-24.	

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	resident's hospital information and saw she was admitted into the hospital on 8/5/24. The information should have been documented in the record. During an interview on 10/29/24 at 11:11 a.m., LPN 4 indicated the resident had gone to dialysis. She was informed the resident's Power of Attorney transferred her to the hospital from the dialysis center, though was unsure who informed her of this and when she was informed. LPN 4 indicated the resident had not been discharged against medical advice and she did not know why she charted that. LPN 4 indicated the dialysis center did not always contact the facility when they sent residents to the hospital. The facility staff had not contacted the dialysis center for information when the resident had not returned to the facility on 8/5/24. During an interview on 10/29/24 at 11:21 a.m., Dialysis Staff 1 indicated the resident's family entered the dialysis center on 8/5/24 and informed them he was taking the resident home after the treatment. The dialysis center had not transferred the resident to the ER, they had discharged her to the family. They had not notified the facility, as they presumed the family member would have informed them. During an interview on 10/29/24 at 11:30 a.m., the Corporate Regional RN indicated improvement was needed with documentation and she was looking for more information. No further information had been received upon exit of the facility on 10/29/24 at 4:00 p.m. An undated hemodialysis policy and procedure, received from the Minimum Data Set (MDS) Nurse		Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/Designee will audit residents return from appointments/dialysis and documentation if resident did not return and reason five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; 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 needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **Date Of Completion: 10-31-2024**	

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	on 10/29/24 at 8:42 a.m., indicated the dialysis center and the facility will communicate information regarding the dialysis session. This citation relates to Complaint IN00440342. 3.1-37(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure a resident's record had thorough and accurate documentation related to a Physician consult appointment, admission cardiac assessment, pressure ulcer assessment, and documentation of pressure ulcers, for 1 of 5 residents reviewed for medical record documentation. (Resident B) Finding includes: Resident B's closed record was reviewed on 10/28/24 at 1:06 p.m. The diagnoses included, but were not limited to stroke. a) A Nurse's Admission Assessment, dated 6/7/24, indicated a pacemaker and defibrillator was present. There were no physician's orders for routine pacemaker monitoring. The Chest Physician Consult from the hospital, dated 6/4/24, lacked documentation of a pacemaker and/or defibrillator. The Nurse Practitioner's Admission Progress Note, dated 6/18/24 at 1:38 p.m., indicated the	F 0842	**Waters of Hobart** **F842** It is the policy of this facility to ensure residents record has thorough and accurate documentation. b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **/bResident B no longer resides at the facility** **/p>** **br>** /p> /p> /p> /p> br> **/p>** **/p>** **br>** **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	10/31/2024

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	cardiovascular status was normal cardiac rhythm and no murmurs. There was no documentation that indicated a pacemaker and defibrillator was present. A Nurse's Progress Note, dated 6/21/24 at 10:27 a.m., indicated an open area in the skin had been found on the resident's left lower back. There was an abdominal binder on that protected a heart monitoring devise, "placed on the upper left side of his chest". There was no further documentation in the record that indicated the resident had a pacemaker, defibrillator, or heart monitor. During an interview on 10/29/24 at 9:28 a.m., the Corporate Regional RN indicated all the hospital paperwork had been read and there was no heart monitor, pacemaker, or defibrillator documented in the records. The nurses who had documented the information were no longer employed by the facility. The Nurse Practitioner completed an assessment after admission and there was no pacemaker, defibrillator, or heart monitor. The nurses may have charted on the wrong record. b) A Nurse's Progress Note, dated 8/20/24 at 3:11 p.m., indicated an appointment with the Neurosurgery and Spine institute on 8/21/24 had been canceled due to being unable to find transportation to the appointment. A new appointment would be rescheduled and gurney transportation could be found. There was no further documentation the appointment had been rescheduled and transportation had been found. During an interview on 10/29/24 at 9:29 a.m., the		**assurance program will be put into place?** **If the facility is within 95% compliance at the end of the 6 months; 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 needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **/b>** **/p>** **/p>** **/b>** **Date Of Completion: 10-31-2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

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	Corporate Regional RN indicated she notified the Neurosurgery and Spine Institute and was informed the appointment was for 8/1/24 and the Physician's Office canceled the appointment after the CT of the head results on 7/12/24 showed the hematoma had resolved. There had been no appointment scheduled on 8/21/24. She indicated it may have been another resident who was scheduled to go to an appointment and there were documentation problems. c) A Weekly Skin Assessment, dated 8/20/24, indicated there were no pressure areas. The Daily Skilled Notes, dated 8/22/24, indicated there were no pressure ulcers. The Skin-Weight-Assessment-Team (SWAT) Progress Notes, dated 8/22/24, indicated there were no pressure ulcers. A Nutrition at Risk Note, dated 8/23/24 at 1:08 p.m. and written by Registered Dietitian (RD) 6, indicated nursing had informed her there were two open areas on the skin, on the sacrum and the back and the Wound Nurse was to evaluate. There was no documentation of the two open areas on the sacrum and back in the Nurses' Progress Notes. During an interview on 10/29/24 at 10:52 a.m., the Corporate Regional RN indicated the meeting on 8/23/24 at been completed per the phone with the RD. She had notified RD 6 and she was unable to recall who informed her about the open areas, only that she was told. This citation relates to Complaints IN00440342 and IN00443034.			

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	3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 5, CNA 1, and QMA 2) when providing care to residents (Residents E and F) who were in Enhanced Barrier Precautions (EBP) for two random observations for infection control. Findings include: 1) During an observation on 10/28/24 at 8:51 a.m., Resident E had a sign on the room door that indicated the resident was in EBP. There was PPE located at the doorway to the room. Upon entering the room, CNA 5 was completing morning care on the resident. Gloves were worn. She indicated she had just finished washing him and provided incontinent care. The feeding tube insertion site was clean. CNA 5 was applying lotion to the resident's legs. She indicated the resident was no longer in EBP and stated, "he doesn't have anything, they just forgot to take the signs down.". She then completed the resident's oral care. Resident E's record was reviewed on 10/29/24 at 10:58 a.m. The diagnoses included, but were not limited to, severe protein deficiency. An Admission MDS assessment, dated 9/15/24, indicated a moderately impaired cognitive status, a feeding tube was present and supplied 51% or	F 0880	**Tag# F880 Infection Prevention and Control** It is the policy of this facility to ensure that enhanced barrier precautions are followed. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Resident E and F were assessed and not negatively affected related to alleged deficient practice by the DON/Designee on 10-28-24. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who reside in the facility have the potential to be affected by this alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** The DON/Designee in-serviced the nursing staff on 10-31-24 related to facility policy and protocol on	10/31/2024

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	more of nutrition and 501 cubic centimeters (cc) or more of fluids daily. He was dependent for bathing and required maximum assistance for hygiene. A Care Plan, dated 10/28/24, indicated EBP was required related to the feeding tube. The interventions included EBP guidelines would be followed with direct care activities, which included, bathing, hygiene, incontinent care. A Physician's Order, dated 10/28/24, indicated EBP was to be used every shift due to the feeding tube and nebulizer treatments. 2. During an observation on 10/28/24 at 9:34 a.m., Resident F's door to the room indicated EBP was required. CNA 1 and QMA 2 were prepared to begin Resident F's morning care. They had donned gloves. Prior to the start of the care, they were interviewed about EBP. QMA 2 indicated the resident was on EBP. CNA 1 and QMA 2 then applied gowns and changed gloves. Morning care was completed, which included incontinent care. The insertion site of the feeding tube was clean and had a clean dressing marked with the date 10/28/24. Resident F's record was reviewed on 10/29/24 at 1:14 p.m. The diagnoses included, but were not limited to, stroke and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 9/5/24, indicated the cognition status was not completed due to the resident was unable to answer, there were no behaviors, dependent for all activities of daily living, always incontinent of bowel and bladder, and had a feeding tube present.		enhanced barrier precautions. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** DON/Designee will complete validation of enhanced barrier precautions are in place on 10 random staff member weekly x 4weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members weekly x 4 weeks then 3 random staff members monthly x 3 months will be completed on. If the facility is within 95% compliance at the end of 6 months, 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 needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date Of Completion: 10-31-2024	

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	A Care Plan, dated 10/28/24, indicated EBP was required related to the feeding tube. The interventions included EBP guidelines would be followed with direct care activities, which included, bathing, hygiene, incontinent care. A Physician's Order, dated 2/7/24, indicated EBP was to be used every shift due to the feeding tube. During an interview on 10/28/24 at 10:30 a.m., the Assistant Director of Nursing was informed of EBP not being followed. No further information was received at this time. A facility EBP policy, dated 12/2022 and received from the Minimum Data Set (MDS) Nurse as current, indicated EBP would be used for residents during high-contact resident care activities for residents who were at risk. The residents at risk included residents with feeding tubes. The high-contact examples included bathing/showering, hygiene, and changing briefs/incontinent care. Gowns and gloves would be utilized. This citation relates to Complaint IN00443034. 3.1-18(b)			