STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00423351 and IN00422321. Complaint IN00423351- No deficiencies related to the allegations were cited. Complaint IN00422321- No deficiencies related to the allegations were cited. Survey dates: December 6, 8, 11, 12, 13, and 14, 2023. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 2 Medicaid: 43 Other: 10 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 21, 2023.	F 0000	**F000** 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 January 12, 2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
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			

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

Jalena Ball | Administrator | 01/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (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			

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	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 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 record review, the facility failed to notify the appropriate physician of laboratory results for 1 of 20 residents reviewed for notification of change. (Resident 24) Findings include: During an observation and interview on 12/06/23 at 1:40 P.M., Resident 24 indicated she currently had a bad UTI. She was on IV (Intravenous) antibiotics. The IV antibiotic was running at the time. The clinical record for Resident 24 was reviewed on 12/12/23 at 9:38 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/11/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, seizure disorder, and depression. An Infectious Disease Physician's Progress Note, dated 08/01/23 at 6:21 P.M., indicated the resident had cloudy urine and was not on antibiotics. A recommendation was made for staff were to obtain urine for a U/A (Urinalysis) C&S (Culture and Sensitivity) and to please email or call with the results. A UA result, dated 08/03/23, indicated the resident had positive nitrate, 2+ leukocytes, rare	F 0580	**F580 Notify of Changes (Injury/Decline/Room, etc.)** It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 24 has received appropriate antibiotics to treat all identified organisms in her urine culture. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by this deficient practice. All residents who have had a urinalysis with culture and sensitivity (UA C&S) in the last 30 days will be identified. The results will be reviewed to determine if the provider was notified of the results and if the correct antibiotic was used to treat any infection that is	01/12/2024

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	bacteria, and increase white blood cell, which were all noted as abnormal. A Culture result final report, verified 08/06/23, indicated the residents urine contained the following bacteria: - Proteus Mirabilis, - Escherichia Coli ESBL (E.Coli), and - Providencia Stuartii. There was no indication in the clinical record that the Infectious Disease NP (Nurse Practitioner) had been provided with the results of the UA C&S. An Infectious Disease Physician's Progress Note, dated 08/10/23 at 9:50 P.M., indicated the resident had cloudy urine and was not receiving any antibiotics. A recommendation was made for staff to obtain urine and for U/A C&S and to please email or call with results. A UA result, dated 08/12/23, indicated the resident had positive nitrate, 1+ leukocytes, rare bacteria, and increase white blood cell, which were all noted as abnormal. A Culture result final report, with a verified date of 08/14/23, indicated the residents urine contained the following bacteria: - Proteus Mirabilis, and - Escherichia Coli ESBL (E.Coli). There was no indication in the clinical record that the Infectious Disease NP had been provided with the results of the UA C&S. During an interview on 12/13/23 at 9:43 A.M., LPN (Licensed Practical Nurse) indicated if the		present. This will be completed by 1/11/24, by DON/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses will be re-educated on the Change of Condition policy and lab policy by 1/11/24, DON/Designee. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. The Director of Nursing or designee will review lab orders during the morning clinical meeting that meets at least 5 times weekly. Any order for a UA C&S will be identified and the lab results will be reviewed to determine if the ordering provider was notified of the results, if an antibiotic is indicated, and the correct antibiotic was prescribed. Any discrepancy will be immediately discussed with the provider that ordered the UA C&S to obtain the correct antibiotic. Findings of this review will be recorded on the UA C&S Compliance Audit. **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 Director of Nursing or	

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	Infectious Disease NP would order a U/A C&S then she would notify both the facility NP and the Infectious Disease NP with the results. The Infectious Disease NP's number was hanging at the nurses station. During an interview on 08/13/23 at 5:00 P.M., the Infectious Disease NP indicated it was really hard to getv the laboratory results from the facility she usually had to hunt them down herself. They don't send any of them to her. She had asked for access to the lab system so she could just log in and see them herself. The facility said they would scan them into the resident electronic record, but they were usually not in the system. She always emails the DON (Director of Nursing) or ADON (Assistant Director of Nursing) with her recommendations, but they sometimes don't get done. She had tried entering the orders in herself, but because they used an outside lab the order doesn't go to them. She would be fine with the facility NP getting the results as long as they treat the UTI (Urinary Tract Infection), a lot of times they don't use the correct antibiotic for the UTI. If she had asked for a UA C&S on 08/01/23 and then again on 08/10/23 then she would not have received the results from the 08/01/23 UA. The current facility policy titled, "Change in Resident's Condition or Status", was provided by the DON on 12/14/23 at 10:21 A.M. The policy indicated, "...It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status..." 3.1-5(a)(3)		designee will complete the UA C&S Compliance Audit weekly for residents that had an order for a UA C&S for a period of not less than 6 months. The UA C&S Compliance Audit will be reviewed during the monthly QAPI meeting to ensure compliance. 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. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **By what date the systemic change for the deficiency will be completed?** Date of Compliance 1/12/24.	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to follow infection control guidelines and follow physician orders for 2 of 8 residents reviewed for pressure ulcers. (Residents 14 and 18) Findings include: 1. During an observation on 12/06/23 at 12:24 P.M., LPN (Licensed Practical Nurse) 5 retrieved Resident 14's treatment supplies from a treatment cart and stopped outside the resident's room. She placed the supplies on top of cart outside the room. She donned a gown, gloves, and a face mask. She picked up the supplies and went into the resident's room. She placed a paper towel on an over bed table and placed the supplies on top. She removed the resident's sheet, and the resident lifted his right stump. She removed an undated dressing and placed it in a garbage can. The dressing had heavy drainage. She removed a gauze from a package, sprayed it would wound cleanser, and cleansed the wound. She removed a collagen sheet and placed it over the wound with	F 0686	**F686 Treatment/Services to Prevent/Heal Pressure Ulcer** It is the policy of this facility to maintain appropriate infection control practices when performing dressing changes. It is the policy of this facility to follow physician orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 14 and 18 had no negative outcome related to the deficient practice and have had their pressure ulcers dressed in accordance with physician orders and appropriate infection control practices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	01/12/2024

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	both hands, covered the wound with an abdominal pad. She misplaced her tape and found some on a bedside table that was stuck to a Dorito bag. She grabbed the tape with her gloved hands and removed the part that was stuck to the bag and removed some more tape and taped the wound dressing. She then proceeded to change a dressing to the left buttock/thigh using the same gloves. She did not wash her hands prior to the treatment and her gloves were not changed until both wound treatments were complete. A Quarterly MDS (Minimal Data Set) assessment, dated 10/31/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, diabetes, depression, and bilateral amputee. The resident had pressure ulcers. A Skin and Wound Note, dated 12/07/23, indicated the resident's right thigh wound had seropurulent drainage and continued to worsen. After consulting with the primary care physician, a wound culture was planned. A Wound Culture Result, with a verified date of 12/12/23, indicated the resident had the following bacteria in the wound: - Moderate Proteus Mirabillis, - Few Klebsiella Pneumoniae ESBL, - Few Escherichia coli, - Few Providencia stuartii, and - Few Streptococcus agalactiae. The resident was started on an antibiotic that was susceptible to the bacteria. During an interview on 12/14/23 at 10:06 A.M., LPN 6 indicated when performing a dressing		**action(s) will be taken?** All residents with pressure ulcers have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses will be re-educated on the following policies by 1/11/24: Non-sterile Dressing Change Guidelines for Physician's Orders (Following Physician's Orders) Signing MAR/TAR An audit of all residents with physician orders for wound treatment and or prevention will be completed by DON/Designee by 1/11/24 to ensure the correct treatment order is in place. IDT will review physician orders and TARS daily in clinical meeting 5 times a week to ensure compliance with physician orders and prevention and treatment of pressure wounds. **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 Director of Nursing or designee will complete the Pressure Ulcer Compliance Audit for all residents with a pressure	

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	change, she wound gather her materials and go to the resident room. She would put the supplies on a clean surface, wash her hands, and don gloves. She would change her gloves and wash her hands after removing old dressing and before moving onto another dressing if the resident had multiple. She would never touch anything in the resident's room during a dressing change, if she did, she would change her gloves. During an interview on 12/14/23 at 10:38 A.M., LPN 6 indicated the resident had a wound culture in the right leg wound and had started on an antibiotic. The current, undated, facility policy titled, "Non-Sterile Dressings" was provided by the DON (Director of Nursing) on 12/14/23 at 12:50 P.M. The policy indicated, :...8. Wash hands and don gloves...11. Remove soiled dressing and place in plastic trash bag...12. Remove soiled gloves and place in plastic trash bag...13. Wash hands...14. Don new gloves..." 2. The clinical record for Resident 18 was reviewed on 12/11/23 at 10:44 A.M. A Quarterly MDS assessment, dated 11/11/23, indicated the resident was moderately cognitively impaired. The diagnosis included, but was not limited to, hypertension. A Wound Assessment, dated 10/19/23, indicated the resident had a Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) pressure ulcer to the coccyx. The wound measured 2.4 cm (centimeters) X (by) 2.9 cm X 0.2 cm. The		ulcer weekly x 4 weeks, then 50% of residents with a pressure ulcer weekly x 4 weeks, then 25% of residents with a pressure ulcer weekly x 16 weeks. The DON/Designee will audit a wound treatment weekly for 6 months. DON/Designee will complete a hand washing audit for 5 nursing staff weekly x 4 weeks, 3 nursing staff weekly x 4 weeks, and 1 nursing staff weekly x 16 weeks. DON/Designee will audit 5 TARs for holes weekly x 4 weeks, 3 TARS for holes weekly x 4 weeks, and 1 TAR for holes weekly x 16 weeks. The Pressure Ulcer Compliance Audit, Hand washing Audit, and Holes in TAR Audit will be reviewed during the monthly QAPI meeting to ensure compliance. 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. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **By what date the systemic change for the deficiency will be completed?** Date of Compliance 1/12/24.	

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	treatment order was to cleanse the wound with wound cleanser, apply medical grade honey, and cover with a bordered foam, daily and as needed. A Wound Assessment, dated 12/07/23, indicated the resident had a Stage 3 pressure ulcer to the coccyx. The wound measured 0.9 cm X 0.5 cm X 0.1 cm. The treatment remained the same as 10/19/23. The Electronic Treatment Administration Record for October and November 2023 were reviewed and indicated the medical grade honey treatment had not started until 11/11/23. The ETAR lacked documentation that the treatment was completed on 11/19/23, 11/21/23, 11/22/23, and 11/27/23. During an interview on 12/14/23 at 12:07 P.M., the ADON (Assistant Director of Nursing) indicated at the time of the wound re-developed on 10/19/23 they were using a paste to the coccyx. The treatment order should have changed to the medical honey. During an interview on 12/14/23 at 12:17 P.M., the Interim DON (Director of Nursing) indicated if there was a blank in the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) it would indicate the mediation or treatment was not done. The current, undated, facility policy titled, "Physician Orders--(Following Physician Orders)" was provided by the Interim DON on 12/13/23 at 2:53 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." The current facility policy, titled "Guidelines for Prevention/Treatment if Pressure Injuries" and			

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	dated 10/09/23, was provided by the Interim DON on 12/14/23 at 12:50 P.M. The policy indicated, "...It is the intent of the facility to recognize the following information and to act on it in such a way as to practice evidence-based recommendations for the prevention/treatment of pressure injuries to the residents who reside in the facility..." 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to treat a UTI (Urinary Tract Infection) appropriately for 1 of 2 residents reviewed for UTI. (Resident 24) Findings include: During an observation and interview on 12/06/23 at 1:40 P.M., Resident 24 indicated she currently had a bad UTI. She was on IV (Intravenous) antibiotics. The IV antibiotic was running at the time. A Quarterly MDS (Minimum Data Set) assessment, dated 11/11/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, seizure disorder, and depression. A UA (Urinalysis) result, dated 09/27/23, indicated the resident's urine was positive for nitrates, had 2+ leukocytes, increased white blood cell count, 3+ bacteria, and increased red blood cells, which were all abnormal. A Physician Progress Note, dated 09/28/23 at 12:19 P.M., indicated the resident was seen due to UA that was positive for a UTI. The resident reported fatigue and malaise over the past couple days. The resident had a history of an indwelling catheter and was noted with strong urine odor.	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** It is the policy of this facility to ensure appropriate antibiotic usage practices are in place, to promote optimal therapeutic and cost-effective care for our residents, and ultimately, reduce the likelihood of developing multi-drug resistant organisms. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 24 has received appropriate antibiotics to treat all identified organisms in her urine culture. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by this deficient practice. All residents who have had a urinalysis with culture and sensitivity (UA C&S) in the last 30 days will be identified. The results	01/12/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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	The residents preliminary culture results were positive for proteus mirabilis and would start the resident on IV Cefazolin (an antibiotic). A Culture final report, with a verified date of 09/30/23, indicated the resident had the following bacteria in her urine: - Proteus Mirabilis, - Escherichia Coli (E.coli) ESBL, and - Providencia Stuartii. The culture indicated the antibiotic medication Cefazolin was only susceptible to the proteus mirabilis and not to the E. Coli and Providencia stuartii. The resident was to administer the Cefazolin from 09/27/23 through 10/05/23. The clinical record lacks indication that the physician or NP (Nurse Practitioner) did not want to change the antibiotic, just that they were aware of the culture results. A UA result, dated 10/09/23, indicated the resident's urine was positive for nitrite, 2+ leukocytes, increased white blood cells, 3+ bacteria, and increased red blood cells, which were all abnormal. A Culture final report, with a verified date of 10/12/23, indicated the resident had the following bacteria: - E.coli ESBL, - Pseudomonas aeruginosa and - E. Coli ESBL #2. A Physician Progress Note, dated 10/12/23 at 5:40		will be reviewed to determine if the provider was notified of the results and if the correct antibiotic was used to treat any infection that is present. This will be completed by 1/11/24 by the DON/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses will be re-educated by DON/Designee on the Antibiotic Stewardship policy and notifying physician of culture results by 1/11/24. Additionally, any staff that fails to comply wit the points of this in-service will be further educated/disciplined as indicated. The Director of Nursing or designee will review lab orders during the morning clinical meeting that meets at least 5 times weekly. Any order for a UA C&S will be identified and the lab results will be reviewed to determine if the ordering provider was notified of the results, if an antibiotic is indicated, and the correct antibiotic was prescribed. Any discrepancy will be immediately discussed with the provider that ordered the UA C&S to obtain the correct antibiotic. Findings of this review will be recorded on the UA C&S Compliance Audit. **How the corrective action(s)**	

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	P.M., indicated the resident was being seen for re-evaluation following a recent diagnosis of UTI, follow-up UA was consistent with persistent UTI. The plan was to restart the IV antibiotics. The resident was administered Cefazolin from 10/12/23 through 10/18/23. The Culture final result, with a verified date of 10/12/23, indicated the bacteria were resistant to Cefazolin. A Progress Note, dated 10/19/23 at 1:40 P.M., indicated the resident's PICC line to the left upper arm was removed per the MD orders. A UA result, dated 10/22/23, indicated the resident was positive for nitrite, 2+ leukocytes, increased white blood cells, and 2+ bacteria which were all abnormal. A Culture result, with a verified date of 10/24/23, indicated the resident had the following bacteria in her urine: - E. Coli ESBL and - Proteus Mirabilis. There was no indication in the clinical record that the physician or NP had been notified of the UA C&S (Culture and Sensitivity) result. An Infectious Disease Physician Progress Note, dated 11/15/23, indicated the resident was being seen with complaints of pain around the indwelling catheter and the urine in the indwelling catheter was dark yellow and there was a moderate amount of white sediment lining the catheter tubing. She was recently treated with an antibiotic. A recommendation was made for a UA		**will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Director of Nursing or designee will complete the UA C&S Compliance Audit weekly for every resident that has an order for a UA C&S for a period of not less than 6 months. The UA C&S Compliance Audit will be reviewed during the monthly QAPI meeting to ensure compliance. 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. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **By what date the systemic change for the deficiency will be completed?** Date of Compliance 1/12/24.	

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	C&S. A UA result, dated 11/16/23, indicated the resident's urine was positive for nitrites, 2+ leukocytes, amorphous, increased white blood cell count, and 1+ bacteria, which were all abnormal. A Culture final result with a verified date of 11/18/23, indicated the resident's urine contained the following bacteria: - Proteus Mirabilis, - Providencia Stuartii, and - E.coli ESBL. A Progress Note, dated 11/19/23 at 10:21 P.M., indicated the UA results were sent to the MD. A Physician Progress Note, dated 11/21/23 at 9:09 A.M., indicated the resident was seen for an indwelling catheter with complaints of urinary leakage around the catheter and dysuria. The plan was to start Imipenem (an antibiotic) for 14 days. The antibiotic was susceptible to the bacteria. During an interview on 12/13/23 at 9:43 A.M., LPN (Licensed Practical Nurse) 4 indicated when a resident had an order for a UA C&S, she would obtain the urine and get it to the lab as soon as possible. When the results came, she would call them to the MD and make sure they got them and see if they wanted to start them on an antibiotic. If the resident had already been started on an antibiotic, then she would make sure they were aware and the results of the culture in case the medication needed to be changed. If the infectious disease NP ordered the UA, then she would call her and the facility NP with the results. She would document everything in the progress			

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	notes. During an interview on 12/13/23 at 11:42 A.M., NP 5 indicated if she would have seen the residents culture results then she would have changed the antibiotics to the appropriate one. During an interview on 12/13/23 at 11:57 A.M., the Interim DON indicated when UA C&S results were received, they would be sent to the MD/NP or the Infectious Disease NP if they were the ones that ordered the UA. The facility tracked infections and the Infection Preventions would determine if the antibiotic was appropriate. If the antibiotic was not appropriate, then the MD would be notified, and a progress note would be made if the medication was going to be changed or not. The current facility policy, titled "Antibiotic Stewardship" with a revised date of 03/14/23, was provided by the Interim DON on 12/13/23 at 1:16 P.M. The policy indicated, "...The facility focuses on improving antibiotic use through Antibiotic (Antimicrobial) Stewardship Program (ASP) to ensure appropriate antibiotic usage practices are in place, to promote optimal therapeutic and cost-effective care for our residents, and ultimately, reduce the likelihood of developing multi-drug resistant organisms..." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the			

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	facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to follow a physician's order related to daily weights for 1 of 3 residents reviewed for nutrition. (Resident 48) Findings included: A Quarterly MDS (Minimum Data Set) assessment, indicated Resident 48 was cognitively intact. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, and depression. An open-ended physician order, with a start date of 10/11/23, indicated the resident was to be weighed daily and to notify the MD or NP (Nurse Practitioner) of weight gain of greater than 5 pounds in 3 days. A Physician Note, dated 10/12/23 at 3:56 P.M., indicated the resident was seen. The plan was to continue daily weights and notify provider if greater than 3 pounds in 24 hours or 5 pounds in 1 week.	F 0692	**F-692 Nutrition/Hydration Status Maintenance** It is the policy of the facility to obtain weights in accordance with physician orders. Resident 48 continues to have daily weights and had no negative outcome due to weights not being obtained as directed by physician order. All residents who reside in the facility have the potential to be affected by this finding. An audit was completed by DON/Designee on 1/11/2024 for all residents with daily weights to ensure all weights were input. Any changes or corrections were addressed and changed as indicated. Director of Nursing/Designee will	01/12/2024

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	The clinical record lacked that the order was changed to reflect the MD notification of weight gain greater than 3 pounds in 24 hours of 5 pounds in 1 week. The resident had the following weight gains or no weight was provided with no indication that the physician was notified: - On 10/14/23 the weight was 204.4 and 10/15/23 the weight was 210.4, a 6 pound weight gain - On 10/21/23 no weight was recorded, - On 10/29/23 the weight was 197.6 and 10/30/23 the weight was 212, a 14.4 pound weight gain, - On 11/04/23 the weight was 197.8 and 11/05/23 the weight was 209, a 11.2 pound weight gain, - On 11/09/23 no weight was recorded, - On 11/11/23 no weight was recorded, - On 11/22/23 no weight was recorded, - On 11/25/23 the weight was 204 and 11/26/23 the weight was 208.4, a 4.4 pound weight gain, and - On 11/29/23 no weight was recorded. During an interview on 12/13/23 at 9:43 A.M., LPN (Licensed Practical Nurse) 4 indicated if the was a daily weight and had a weight gain then she would call the MD and document in a progress note. During an interview on 12/14/23 at 12:04 P.M., LPN 6 indicated when the NP/MD came into see a resident they would give the nurse verbal orders or input their own orders. The nurse working the floor is who would transcribe the order. The current facility policy titled, "Guidelines for Obtaining Residents' Weights" dated 07/24/23, was provided by the Clinical Support Nurse on 12/14/23 at 2:55 P.M. The policy indicated,		monitor all residents with daily weight orders 5 days weekly for 4 weeks. Then all residents with daily weights weekly for 4 weeks and then 1 resident weekly for 4 months. If the facility is within 95% compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Director of Nursing on 1/11/2024 for all nurses the following was reviewed: 1 Guidelines for Obtaining Resident's Weights 2 Entering weights into MAR/TAR Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?**	

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	"...Accuracy with weight measurements is essential for residents in the long-term care setting. Weight measurement is used to calculate energy, protein, and fluid needs. Further, weight is an indicator of nutritional and health status and changes in weight can often indicate other medical changes. Inaccurate weight measurements can result in an increased number of [unplanned] weight changes in the facility-and can affect the plans of care for the residents..." 3.1-46(a)(1)		Date of Compliance 1/12/2024	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to coordinate care related to the physician's dialysis form to decrease a resident's medication for 1 of 2 residents reviewed for dialysis. (Resident 42) Findings include: A Quarterly MDS (Minimum Data Set) assessment, dated 11/10/23, indicated Resident 42's cognition was moderately impaired. The resident's diagnoses included, but were not limited to, renal insufficiency and diabetes. The resident received dialysis treatments while a resident. The Dialysis Communication binder was reviewed on 12/12/23 at 9:09 A.M. A "Physicians Order	F 0698	**F-698 Dialysis** It is the policy of the facility to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Including but not limited to following physician orders on the physician's dialysis form. The medication order error was corrected on 12/13/23 for resident 24. All residents who reside in the	01/12/2024

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	Sheet" with a note, dated 11/22/23, indicating the resident's Nifedipine medication was to be decreased from 90 mg (milligrams) to 60 mg daily per the Dialysis NP (Nurse Practitioner) 2. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for November and December 2023, was provided by the Interim DON (Director of Nursing) on 12/12/23 at 12:09 P.M. The record indicated the resident had a current order, with a start date of 10/12/23, for Nifedipine 90 mg by mouth at bedtime. During an observation of the Physician's Order Sheet, on 12/12/23 at 11:47 A.M., LPN 3 indicated the orders were reviewed by the nurse on the floor upon the resident's return from dialysis. The nurse on the floor should have received the paperwork and put the new orders in the computer. The undated Community Hemodialysis Policy and Procedure was provided by the Interim DON on 12/12/23 at 12:09 P.M. The policy indicated, "...Purpose...To ensure coordination of care for residents requiring hemodialysis in the community...All residents that are admitted to the facility with needs for hemodialysis will have coordination of services between the facility and the hemodialysis unit...A dialysis communication sheet will return with the resident after the dialysis session to communicate to the facility information regarding the dialysis session..." The current "Guidelines For Physician Orders" policy and procedure, dated 06/18/23, was provided by the Interim DON on 12/12/23 at 12:09 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician...All physician orders received pertaining to the		facility have the potential to be affected by this finding. An audit was completed by the DON/Designee for all residents on dialysis to ensure any orders relayed on the dialysis form were in place. Any changes or corrections were addressed and changed as indicated. Director of Nursing/Designee will monitor dialysis communication forms for all dialysis residents weekly for 6 months. If the facility is within 95% compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Director of Nursing on 1/11/2024 for all nurses the following was reviewed: 1 Order entry 2 Dialysis communication form Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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	

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	resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received..." 3.1-37(a)		written Action Plan will be monitored by the Administrator weekly until resolution. **By what date the systemic change for the deficiency will be completed?** Date of Compliance 1/12/2024	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide the required RN coverage on duty for eight hours a day for 5 of the 16 days reviewed. Findings include: The as worked nursing schedule indicated there had not been an RN on duty for eight consecutive hours on the following dates: - Saturday 11/04/23, - Sunday 11/05/23,	F 0727	**F-727 RN 8 hours/7 days/Wk, Full Time DON** It is the policy of the facility to ensure Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The facility is engaged in continual efforts to recruit and retain licensed nurses	01/12/2024

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	- Saturday 11/25/23, - Saturday 12/09/23, and - Sunday 12/10/23. During an interview on 12/14/23 at 2:51 P.M., the Administrator indicated the facility did not have an RN on duty for eight consecutive hours for the days reviewed and they did not have any nurse waivers. The facility did not have a policy for RN coverage, they followed State and Federal regulations. 3.1-17(b)(3)		in order to comply with RN coverage dictated by CMS. These efforts are documented and available for review. No resident has been negatively impacted by this finding. Residents who reside in the facility have the potential to be affected by this finding. The facility will provide 8 continuous hours of Registered Nursing services 7 days per week. DON/Designee will monitor RN labor hours 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then weekly ongoing for a period of no less than 6 months. If facility is within 95% compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on 1/05/2024 for the DON, ADON and Staffing Coordinator the following was reviewed: 1. Federal regulation related to RN staffing requirements 2. Scheduling strategy to ensure 8hrs of consecutive RN coverage is present daily. Any staff who fail to comply with	

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			the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?** Date of Compliance 1/12/2024	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow physician orders related to medication hold parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 12/12/23 at 9:38 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/11/23, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, seizure disorder, and depression. An open-ended physician's order, with a start date of 04/05/23, indicated the staff were to administer Metoprolol Tartrate (a blood pressure medication) 12.5 mg (milligrams), twice a day, for hypertension. The medication was to be held if the resident's systolic blood pressure (top number) was less than 110. The medication was not held the following dated and times when the resident's systolic blood pressure was less than 110: - 09/16/23 at 8:00 A.M., when the resident's blood pressure was 103/60, - 09/17/23 at 8:00 P.M., when the resident's blood pressure was 104/62,	F 0757	**F-757 Drug Regimen is Free from Unnecessary Drugs** It is the policy of the facility to ensure each resident's drug regimen must be free from unnecessary drugs. Including but not limited to following physician orders related to medication hold parameters. Medication errors for resident 24 were discussed with the nurse practitioner on 12/14/23. The nurse practitioner evaluated the resident and adjusted medication. All residents who reside in the facility have the potential to be affected by this finding. An audit was completed by the DON/Designee for all residents that have medication hold parameters, with physician notification if errors were found. Director of Nursing/Designee will monitor medication administration withhold parameters for 10 residents weekly for 4 weeks, 5 residents weekly for 4 weeks and then 1 resident weekly for 4 months. If facility is within 95%	01/12/2024

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	155233	A. BUILDING 00 B. WING	12/14/2023

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	- 09/29/23 at 8:00 A.M., when the resident's blood pressure was 107/64, - 10/22/23 at 8:00 A.M., when the resident's blood pressure was 105/62, - 11/08/23 at 8:00 P.M., when the resident's blood pressure was 107/74, - 12/07/23 at 8:00 A.M., when the resident's blood pressure was 103/63, and - 12/09/23 at 8:00 A.M., when the resident's blood pressure was 93/61. An open-ended physician's order, with a start date of 07/07/23, indicated the staff were to administer Midodrine, 5 mg, three times a day, for low blood pressure. The medication was to be held if the resident's systolic blood pressure was greater than 130. The medication was not held on the following dates and times: - 09/19/23 at 11:00 A.M., when the resident's blood pressure was 160/80, - 09/22/23 at 4:00 P.M., when the resident's blood pressure was 139/82, - 09/25/23 at 11:00 A.M., when the resident's blood pressure was 135/82, - 09/27/23 at 11:00 A.M., when the resident's blood pressure was 137/75, - 09/30/23 at 4:00 P.M., when the resident's blood pressure was 146/85, - 10/01/23 at 11:00 A.M., when the resident's blood pressure was 155/84, - 10/14/23 at 7:00 A.M., when the resident's blood pressure was 140/80, - 10/28/23 at 7:00 A.M., when the resident's blood pressure was 143/86, - 10/29/23 at 11:00 A.M., when the resident's blood pressure was 134/66, - 11/01/23 at 7:00 A.M., when the resident's blood		compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Director of Nursing on 1/11/2024 for all nurses the following was reviewed: 1 Medication administration 2 Holding medications with parameters Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?** Date of Compliance 1/12/2024	

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	pressure was 142/76, - 11/05/23 at 11:00 A.M., when the resident's blood pressure was 139/78, - 11/06/23 at 11:00 A.M., when the resident's blood pressure was 133/72, and 4:00 P.M., when the blood pressure was 138/78, - 11/10/23 at 7:00 A.M., when the resident's blood pressure was 152/87, and 11:00 A.M., when the blood pressure was 136/80, - 11/11/23 at 7:00 A.M., when the resident's blood pressure was 149/72, 11:00 A.M., when the blood pressure was 137/84, and 4:00 P.M., when the resident's blood pressure was 136/70, and - 11/17/23 at 7:00 A.M., when the resident's blood pressure was 134/77. During an interview on 12/13/23 at 9:43 A.M., LPN (Licensed Practical Nurse) 4 indicated if a medication had hold parameters then the medication would be held based on the parameters. She would mark on the EMAR (Electronic Medication Administration Record) that the medication was not administered and input a progress note. The current, undated, facility policy titled, "Physician Orders--(Following Physician Orders)" was provided by the Interim DON (Director of Nursing) on 12/13/23 at 2:53 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-48(a)(3)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility	F 0760	**F-760 Residents are Free from**	01/12/2024

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	failed to ensure a resident received the prescribed significant medications upon admission for 1 of 20 residents reviewed. (Resident 53) Findings include: An Admission MDS (Minimum Data Set) assessment, dated 09/14/23, indicated the Resident 53 was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, septicemia, anxiety, and respiratory failure. A Progress Note, dated 09/08/23 at 4:27 P.M., indicated the resident arrived to the facility via EMT (Emergency Medical Technician). A Progress Note, dated 09/21/23 at 2:28 P.M., indicated the nurse found four prescriptions from the admitting hospital infectious disease doctor that were written on 09/06/23 for antibiotics and labs. The resident had not received them. She would follow up with the MD tomorrow. The hospital discharge scripts, dated 09/06/23 indicated the resident was to receive the following: - IV (Intravenous) Penicillin (an antibiotic) 3 million units, six times daily, until 09/15/23 for possible neurosyphilis, - IV Ertapenem 1 gram daily until 09/12/23, for Enterobacter Bacteremia, - PICC Care and please remove PICC at the completion of IV antibiotics, - White Blood Cell, Platelet Count, BUN/Creatin, hepatic function panel, weekly while on antibiotics. During an interview on 12/13/23 at 9:43 A.M., LPN		**Significant Med Errors** It is the policy of the facility to ensure all residents are free of any significant medication errors. The medication error for resident 53 was identified by facility staff on 9/20/23 and discussed with the hospital infectious disease nurse practitioner (ID NP) that ordered the medications upon hospital discharge. Facility staff entered a new order for doxycycline as instructed by ID NP. All residents who reside in the facility have the potential to be affected by this finding. A 30 day look back of new admissions was completed by DON/Designee on 1/11/2024 to ensure that all medications were transcribed. DON/Designee will monitor medication administration for 10 residents, 5 days weekly for a period of 4 weeks. The tool will then be used for 5 residents, 3 days weekly for a period of 4 weeks, then weekly for 1 resident ongoing for a period of no less than 4 months. If the facility is within 95 % compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the DON/Designee on 1/11/2024 for all	

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	(Licensed Practical Nurse) 4 indicated when a resident admitted to the facility from the hospital all their medication orders were to transcribe to the electronic health record. The nurse was to go through the hospital paperwork. If there were any written prescriptions, they would be entered and faxed to the pharmacy. During an interview on 12/13/23 at 1:49 P.M., the Interim DON (Director of Nursing) indicated when a resident admitted from the hospital the nurse would process all the orders as indicated. The nurse would review the paperwork. If the resident came with written prescriptions, then they would be faxed to the pharmacy. Medication orders should be put in as soon as possible or within 24 hours. The current, undated, facility policy titled, "Medication Administration Errors", was provided by the Interim DON on 12/14/23 at 10:21 P.M. The policy indicated, "...A medication error is any preventable event that may cause or lead to inappropriate medication use..." The current, undated, facility policy titled, "Admission Orders" was provided by the Interim DON on 12/13/23 at 2:53 P.M. The policy indicated, "...Upon admission/readmission, orders for care of the resident are received from the physician, placed on physician's order sheet and filed in the health record..." The current, undated, facility policy titled, "Physician Orders--(Following Physician Orders)" was provided by the Interim DON on 12/13/23 at 2:53 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..."		nursing staff the following was reviewed: 1. Medication administration 2. Mar documentation Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?** Date of Compliance 1/12/2024	

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	3.1-48(c)(2)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which			

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	the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice,			

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	and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data,			

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	including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review, the facility failed to demonstrate that ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers, that were previously cited on the last annual survey, for 1 of 13 care areas reviewed. (Pressure Ulcers) Findings include: During the Annual Recertification and complaint survey, from 12/06/23 to 12/14/23, one deficiency was a repeated citation from the last annual survey, F686. The facility's Quality Assurance Committee did not implement on-going appropriate measures to correct identified issues or prevent deficiencies as follows: 1. Pressure Ulcers: 2 residents did not received appropriate infection control measures and physician orders followed. During an interview on 12/14/23 at 12:33 P.M., the Administrator indicated the QAPI involved their entire IDT (Interdisplinary Team). They invite Certified Nurse Aides and Nurses because the want the entire building involved to help things flow. They meet monthly. They usually always review wounds, infections, medications, discharges, turnover, admissions, marketing, resident council, dietary, medical record reviews, and billing. They try to go over everything. All departments focus on something in their department. If there was an area of concern then	F 0867	**F-867 QAPI/QAA Improvement Activities** It is the policy of the facility to have a Quality assurance and performance improvement (QAPI) program. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. Including demonstrating ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers. Residents who reside in the facility have the potential to be affected by this finding. A QA audit was completed DON/Designee on 1/11/2024 to ensure the PIP for pressure ulcers was current, monitoring was taking place as indicated by the plan and all residents had appropriate orders in place related to pressure ulcers. DON/Designee will monitor QAPI	01/12/2024

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	they decide if they need to make an action plan for it. They are supposed to bring audits to QAPI and the IDT reviews them to see if things need to change. They had a QAPI for pressure ulcers from May through August 2023. She was able to find some audit forms from May and June but it obviously didn't work if there was still a problem if it was being cited again. The current "Quality Assurance/Performance Improvement Program (QAPI)" was provided by the Administrator on 12/08/23 at 12:34 P.M. The policy indicated, "...To provide a process that will enhance the care and experience for all residents, improve the work environment for stakeholders, and quality of all services provided by the facility..." Cross reference F686 3.1-52(b)(2)		plans and PIPs 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on 1/11/2024 for the IDT the following was reviewed: 1. QAPI policy and procedure 2. PIP documentation and review related to QAPI Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?** Date of Compliance 1/12/2024	

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F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview the facility failed to appropriately track and monitor a resident's urinary track infections for 1 of 2 residents reviewed for UTI's. (Resident 24) Findings include: 1. A Quarterly MDS (Minimum Data Set) assessment, dated 11/11/23, indicated Resident 24 was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, seizure disorder, and depression. A UA (Urinalysis) result, dated 09/27/23, indicated the resident's urine was positive for nitrates, had 2+ leukocytes, increased white blood cell count, 3+ bacteria, and increased red blood cells, which were all abnormal. A Physician's Progress Note, dated 09/28/23 at 12:19 P.M., indicated the resident was seen due to UA that was positive for a UTI. The resident reported fatigue and malaise over the past couple days. The resident had a history of indwelling catheter and had a strong urine odor. The residents preliminary culture results were positive for proteus mirabilis and they would start the	F 0881	**F881 Antibiotic Stewardship Program** It is the policy of the facility to establish an infection prevention and control program (IPCP) that includes an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 24 has received appropriate antibiotics to treat all identified organisms in her urine culture. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**	01/12/2024

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	resident on IV Cefazolin (an antibiotic). A Culture final report, with a verified date of 09/30/23, indicated the resident had the following bacteria in her urine: - Proteus Mirabilis, - Escherichia Coli (E.coli) ESBL, and - Providencia Stuartii. The culture indicated the antibiotic medication Cefazolin was only susceptible to the proteus mirabilis and not to the E. Coli and Providencia stuartii. The resident was administered Cefazolin from 09/27/23 through 10/05/23. The clinical record lacked indication that the physician or NP (Nurse Practitioner) did not want to change the antibiotic just that they were aware of the culture results. A UA result, dated 10/09/23, indicated the resident's urine was positive for nitrite, 2+ leukocytes, increased white blood cells, 3+ bacteria, and increased red blood cells, which were all abnormal. A Culture final report, with a verified date of 10/12/23, indicated the resident had the following bacteria: - E.coli ESBL, - Pseudomonas aeruginosa and - E. Coli ESBL #2. A Physician's Progress Note, dated 10/12/23 at 5:40 P.M., indicated the resident was being seen for re-evaluation following a recent diagnosis of		All residents have the potential to be affected by this deficient practice. All residents who have had a urinalysis with culture and sensitivity (UA C&S) in the last 30 days will be identified. The results will be reviewed to determine if the provider was notified of the results and if the correct antibiotic was used to treat any infection that is present. This will be completed by 1/12/24 by the DON/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** At an in-service held by the Regional Nurse Consultant on 1/11/2024 for the DON and ADON the following was reviewed: 1 antibiotic stewardship policy and procedure 2 Antibiotic stewardship tracking and trending. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. The Director of Nursing or designee will review lab orders during the morning clinical meeting that meets at least 5 times weekly. Any order for a UA	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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	UTI, follow-up UA was consistent with persistent UTI. The plan was to restart the IV antibiotics. The resident was administered Cefazolin from 10/12/23 through 10/18/23. The Culture final result, with a verified date of 10/12/23, indicated the bacteria were resistant to Cefazolin. During an interview on 12/13/23 at 11:42 A.M., NP 5 indicated if she would have seen the resident's culture results then she would have changed the antibiotics to the appropriate one. During an interview on 12/13/23 at 11:57 A.M., the Interim DON (Director of Nursing) indicated when UA C&S results were received, they would be sent to the MD/NP or the Infectious Disease NP if they were the ones that ordered the UA. The facility tracked infections and the Infection Preventions would determine if the antibiotic was appropriate. If the antibiotic was not appropriate, then the MD would be notified, and a progress note would be made if the medication was going to be changed or not. All infections would be tracked in the infection control log. Resident 24's EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated she had received the following antibiotics: - Cefazolin from 09/28/23 through 10/05/23 and - Imipenem from 11/24/23 through 12/07/23. The Infection Control Tracking and Trending was provided by the Interim DON on 12/13/23 at 3:30 P.M. The October and November 2023 Tracking logs indicated the resident was on antibiotics for		C&S will be identified and the lab results will be reviewed to determine if the ordering provider was notified of the results, if an antibiotic is indicated, and the correct antibiotic was prescribed. Any discrepancy will be immediately discussed with the provider that ordered the UA C&S to obtain the correct antibiotic. Findings of this review will be recorded on the UA C&S Compliance Audit. **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 Director of Nursing or designee will complete the UA C&S Compliance Audit weekly for every resident that has an order for a UA C&S for a period of not less than 6 months. The UA C&S Compliance Audit will be reviewed during the monthly QAPI meeting to ensure compliance. 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. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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	the above infections. The current facility policy, titled "Antibiotic Stewardship" with a revised date of 03/14/23, was provided by the Interim DON on 12/13/23 at 1:16 P.M. The policy indicated, "...The facility focuses on improving antibiotic use through Antibiotic (Antimicrobial) Stewardship Program (ASP) to ensure appropriate antibiotic usage practices are in place, to promote optimal therapeutic and cost-effective care for our residents, and ultimately, reduce the likelihood of developing multi-drug resistant organisms..."		stopped. **By what date the systemic change for the deficiency will be completed?** Date of Compliance 1/12/24.	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any			

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	changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).			
	Based on record review and interview, the facility failed to provide COVID-19 booster immunizations in a timely manner for 2 of 6 residents reviewed for immunizations. (Residents 10 and 53) Findings include:	F 0887	**F-887 Covid-19 Immunization** It is the policy of the facility to develop and implement policies and procedures to ensure Covid-19 vaccines and boosters are offered	01/12/2024

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	1. The clinical record for Resident 10 was reviewed on 12/11/23 at 10:14 A.M. The resident was admitted on 06/14/23. A Quarterly MDS (Minimum Data Set) assessment, dated 11/04/23, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes and chronic obstructive pulmonary disease. The "Informed Consent - Vaccination - COVID-19" record, signed by the resident and the resident's representative on 06/15/23, indicated the resident had received a copy of the most current COVID-19 Fact Sheet as published by the CDC (Centers for Disease Control), the resident understood the benefits and risks associated with the vaccine and consented to receive the vaccination as determined by current CDC guidelines. The resident had received the following COVID-19 immunizations: - dated 03/03/21, - dated 03/31/21, - dated 11/24/21, and - dated 12/13/22, prior to admission. The clinical record lacked documentation the resident had received a COVID-19 booster vaccine since 12/13/22 or following admission on 06/14/23. The Infection Control Log was provided by the Interim DON (Director of Nursing) on 12/12/23 at 8:35 A.M. The record indicated the resident tested positive for COVID-19 on 11/01/23. The Progress Notes, from 06/14/23 to present, lacked documentation the resident had been		and administered in a timely manner. Residents who reside in the facility have the potential to be affected by this finding. *A* facility wide audit was completed by the Director of Nursing and Regional Nurse Consultant to ensure all residents who want to receive the covid-19 vaccine and or booster have a signed consent and receive the vaccine if eligible. All residents who have a signed consent form have had the vaccine ordered to be given on 1/5/24. All residents (or responsible party) who did not have a consent on file, or who did not previously sign a declination form, will be asked to sign a new consent/declination by 1/12/24. Vaccines will be immediately ordered for those who consent. DON/Designee will audit Covid-19 vaccine consent for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within 95 % compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Director of Nursing on 1/11/2024 for all nursing staff the following	

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	offered a COVID-19 booster vaccine. The current, completed, and discontinued physician's orders, from 06/14/23 to present, lacked orders for a COVID-19 booster vaccine. 2. The clinical record for Resident 53 was reviewed on 12/11/23 at 10:25 A.M. The resident was admitted on 09/08/23. An Admission MDS assessment, dated 09/14/23, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to heart failure, anxiety, and respiratory failure. The "Informed Consent - Vaccination - COVID-19" record, signed by the resident on 09/18/23, indicated the resident had received a copy of the most current COVID-19 Fact Sheet as published by the CDC, the resident understood the benefits and risks associated with the vaccine and consented to receive the vaccination as determined by current CDC guidelines. The resident had received the following COVID-19 immunizations: - dated 12/24/21, - dated 01/21/22, and - dated 06/21/22, prior to admission. The clinical record lacked documentation the resident had received a COVID-19 booster vaccine since 06/21/22 or following admission on 09/08/23. The Infection Control Log was provided by the Interim DON on 12/12/23 at 8:35 A.M. The record indicated the resident tested positive for COVID-19 on 11/16/23.		was reviewed: 1 covid-19 immunization policy and procedure 2 procedure for ordering covid-19 vaccine from united rx Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. 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 change for the deficiency will be completed?** Date of Compliance 1/12/2024	

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	The Progress Notes, from 09/08/23 to present, lacked documentation the resident had been offered a COVID-19 booster vaccine. The current, completed, and discontinued physician's orders, from 09/08/23 to present, lacked orders for a COVID-19 booster vaccine. During an interview on 12/11/23 at 11:58 A.M., the Interim DON indicated they had called the Regional Nurse Consultant, and they did not know when the last COVID-19 vaccine clinic was conducted in the building. During an interview on 12/11/23 at 3:16 P.M., the Administrator indicated they were working on scheduling a clinic for the new booster. A CDC (Centers for Disease Control) press release, dated 09/12/23, indicated, "... Updated COVID-19 vaccines from Pfizer-BioNTech and Moderna will be available later this week. Vaccination remains the best protection against COVID-19-related hospitalization and death. Vaccination also reduces your chance of suffering the effects of Long COVID, which can develop during or following acute infection and last for an extended duration. If you have not received a COVID-19 vaccine in the past 2 months, get an updated COVID-19 vaccine to protect yourself this fall and winter..." The current "Moderna COVID-19 Vaccine - Standing orders for Administering Vaccine" policy dated 10/05/23, was provided by the Interim DON on 12/11/23 at 2:44 P.M. The policy indicated, "...Purpose...To reduce morbidity and mortality from coronavirus disease 2019 (COVID-19) by vaccinating persons who meet the criteria established by the Centers for Disease			

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	Control and Prevention's Advisory Committee on immunization Practices (ACP)..." The current "GUIDELINES FOR POST COVID-19 PHE (Public Health Emergency) Which Ended 5/11/23...as related to Nursing Homes" policy, with an effective date of 05/11/23, was provided by the Interim DON on 12/11/23 at 1:41 P.M. The policy indicated, "...testing requirements expired with the PHE on May 11, 2023. However, the nursing home will be mindful of accepted standard of practice related to Covid-19 according to CDC and this will be maintained...This nursing home will continue to educate and offer the Covid-19 vaccine to residents beyond the end of the PHE as part of the Requirements of Participation, through May 2024..." 3.1-18(b)(1)			