STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428769 Complaint IN00428769 - Federal/state deficiencies related to the allegations are cited at F660. Survey date: 2/21/2024 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Census Bed Type: SNF/NF: 90 SNF: 6 Total: 96 Census Payor Type: Medicare: 3 Medicaid: 56 Other: 37 Total: 96 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/23/24.	F 0000	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: 03/12/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of			

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

Roberta Scott Shull | Executive Director | 03/04/2024

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	factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact			

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	agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on record review and interview, the facility failed to develop a comprehensive discharge care plan for 2 of 3 residents reviewed for discharge. (Residents C & B) Findings include: 1. A record review for Resident C was completed on 2/21/2024 at 9:32 A.M. Diagnoses included, but	F 0660	="" b=""> **="" b=""> ** /b> What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident B and C no longer reside	03/12/2024

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	were not limited to: nondisplaced fracture of second metatarsal left foot, normal pressure hydrocephalus, and cerebral infarction. A document titled, "Social Service Progress Note-Resident Interview," dated 1/28/2024, indicated Resident C's response to return to the community was yes, but previously unknown, and a referral to a Local Contact Agency may not be needed. A Social Service Progress Note, dated 1/29/2024 at 12:11 P.M., indicated Resident C had a Care Plan Meeting on 1/31/2024 at 3:30 P.M., and Resident C's plan was to discharge to home with her son. A document tilted, "Social Service Evaluation", dated 1/31/2024, indicated Resident C's desire for discharge was to go home with home health care services. A Care Plan Meeting Progress Note, dated 1/31/2024 at 3:46 P.M., indicated that family was in attendance, and the resident and family goals were to ret rid of the CAM (controlled action motion) boot on the left leg and to gain strength to walk safely. An Admission Minimum Data Set (MDS) assessment, dated 1/31/2024, indicated Resident C was cognitively intact. She required the use of a walker and wheelchair during her stay at the facility. She needed substantial to maximum assistance for toileting and bed mobility and was dependent for transfers. Resident C's goal was to be discharged to the community, and active discharge planning had not occurred. There was no care plan in Resident C's record developed for discharge.		at the facility. 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 for discharge care plans for all residents and any deficiencies were immediately corrected on 2/22/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator completed an in-service with social service and MDS on completion of a comprehensive discharge care plan on 02/22/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 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: The SSD/Designee will audit 10 random residents, new admission, and readmission weekly for a comprehensive discharge plan of care weekly x 4 weeks the 5 random residents, new admission, and re-admissions weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the	

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	A Social Service Note, dated 2/15/2024 at 7:38 A.M., and documented as a late entry on 2/19/2024 at 7:40 A.M., indicated the durable medical equipment (DME) company could not provide a wheelchair due to Resident C's insurance, but Resident C could rent one from the DME company. During an interview, on 2/21/2024 at 10:26 A.M., the Social Service Director (SSD) indicated, when the baseline care plan meeting occurred, the facility should have a good idea if the resident will be a short-term or long-term stay. She had not been creating the discharge care plan like she was supposed to, but rather documenting the baseline care plan meeting notes. On 2/21/2024 at 10:55 A.M., Physical Therapist Assistant 2 indicated he was unaware the facility was discharging Resident C, and had last seen her on 2/13/2024. When he returned to work after vacation, he was told she was going home. On 2/21/2024 at 11:05 A.M., the Therapy Program Manager indicated Resident C wanted to return home before her twentieth day of therapy, so she did not need to pay a co-payment for a further stay. Resident C was not safe to discharge, but the facility was discharging the resident. A prior home assessment had been completed during a previous stay. On 2/21/2024 at 11:36 A.M., the Social Service Director indicated Resident C wanted to go home. Resident C indicated her last covered insurance day was Saturday (2/17/2024). The SSD talked with the Business Office Manager to determine when discharge could occur, and was told February 14-17. Resident C was told the		monitoring will stop. 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 resolve. By what date the systemic changes for each deficient will be completed. March 12, 2024	

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	information, and made the decision to discharge. On 2/21/2024 at 12:35 P.M., Resident C's medical representative indicated there was no prior authorization for a wheelchair needed for discharge, and the home was not wheelchair accessible for the discharge. Home health care had been arranged, but conflicted with the prior home health care company, causing delay in treatment. 2, The closed record for Resident B was reviewed on 2/21/2024 at 9:39 AM. Resident B was admitted to the facility on 1/25/2024 with diagnosis including, but not limited to: Fracture of the first thoracic vertebra from a fall. Resident B discharged from the facility on 2/15/2024. The Admission MDS assessment, dated 1/29/2024, indicated the resident was cognitively intact, and her plan was to discharge to the community, but there was no discharge plan in place. The Care Plans for Resident B did not include any plan addressing the resident's discharge needs. A Care Plan Meeting Progress Note, dated 1/29/2024, indicated the resident's DME (Durable Medical Equipment) needs were unknown at the time, the resident had a walker, wheelchair, cane, and commode at home, and plans were to stand better and walk with stability. There was no specific information regarding the resident's discharge to home. There were no further notes regarding Resident B's discharge, until 2/15/2024, which indicated the nurse practitioner had given orders for the resident to be discharged home with medications, and the discharge summary was reviewed with Resident B and her daughter and son in law.			

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	During an interview with the Social Service Director, on 2/21/2023 at 10:11 A.M., she indicated she did not need a discharge care plan but did discuss the discharge with the resident and her family. The SSD was not certain if she documented every discharge meeting in the clinical record. This citation relates to Complaint IN00428769. 3.1-12(a)(18) 3.1-12(a)(19) .			