STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00450054, IN00451947 and IN00456622. Complaint IN00450054 -- Federal/state deficiencies related to the allegations are cited at F656 and F677 Complaint IN00451947 -- Federal/state deficiency related to the allegations is cited at F550. Complaint IN00456622 -- Federal/state deficiencies related to the allegations are cited at F580 and F842. Unrelated deficiency is cited. Survey dates: March 31, April 1 and 2, 2025 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 1 Medicaid: 48 Other: 6 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 7, 2025.	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 April 25, 2025. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherice Ricks	administrator	04/18/2025

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to honor a resident's right for dignity to 2 of 5 residents reviewed for timely response to call lights and 1 of 1 resident reviewed for incontinence care by offering an incontinence brief. (Resident C and Resident F) Findings include: 1. In an interview with Resident C on 3-31-25 at 1:46 p.m., she indicated the minimum amount of time it took to get her call light answered was typically 30 minutes and this reflected all shifts, but especially night shift. She indicated she had been a resident of the facility for over five years. The clinical record of Resident C was reviewed on 3-31-25 at 12:05 p.m. Her most recent Minimum Data Set assessment, dated 3-15-25, indicated she was cognitively intact. 2. In an interview with a family member of Resident F on 4-1-25 at 2:46 p.m., she indicated earlier in the day, the resident had activated the call light to request toileting assistance. She added the call light had been on for about 20 minutes when she (the family member) then went to the nurse's station and found several staff members present and requested they assist the resident with toileting. She indicated she left the area for approximately 10 minutes and upon return, was informed by the staff that the resident was on the toilet. She indicated when she returned to the resident's room, she found the resident still waiting for assistance. She indicated in the recent past, she had received phone calls from the resident that she had her call light on for 30	F 0550	F 550 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 4/25/2025. Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the intent of this facility to answer call lights in a timely manner. What corrective action will be accomplished for those residents found to have been affected by the deficient practice The DON/Designee assessed resident C on 4/18/2025, no negative outcome related to the alleged cited practice. Resident F no longer resides in 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. All residents that reside in the facility have the potential to be affected by the cited practice,	04/25/2025

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	minutes or more without a staff response and had asked her to call the facility's main line to gain access for assistance for the resident. The family member indicated since Resident F was admitted over one month ago, the resident has been offered by staff to wear an incontinence brief. "They kept offering her a diaper and we have refused it every time. After a week of being told this, we told them not to offer that anymore. That is humiliating for anyone, but someone as young as she is." The clinical record of Resident F was reviewed on 4-2-25 at 11:14 a.m. Her admission Minimum Data Set assessment, dated 2-19-25, indicated she was less than 50 years old, was cognitively intact, was non-ambulatory, required substantial assistance from staff for toileting and was occasionally incontinent of urine and frequently incontinent of stool. In an interview with the Director of Nursing (DON) on 4-2-25 at 10:05 a.m., he indicated it would be difficult to put a numeric value on how quickly he expected call lights to be answered, as it was dependent on time of day and what might be going on in the facility, but expected the staff to respond as quickly as possible to all call lights. On 4-1-25 at 2:30 p.m., the DON provided a copy of a policy entitled, "Call Light, Use of," with a review date of 1-1-2020. This policy indicated its purpose as, "To respond promptly to resident's call for assistance...All facility personnel must be aware of call lights at all times. Answer ALL call lights promptly whether or not you are assigned to the resident..." On 4-2-25 at 4:35 p.m., the Corporate Nurse		therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Director of Nursing or designee will have completed education with staff on answering call lights timely by 4/23/2025. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively 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 DON/Designee will audit call light response times on 20 random residents on random shifts weekly x 4 weeks, then 10 random residents on random shift weekly x 4 weeks, then 5 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator	

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	provided a copy of a policy entitled, "Dignity," dated 8-9-2023. This policy indicated, "Staff will be polite and respectful at all times...Residents will be allowed to wear what they choose if at all possible...Staff will honor the resident's preferences as much as possible...Should a resident have an episode of incontinence, staff will change them upon discovery of the episode." This citation relates to Complaint IN00451947. 3.1-3(t) 3.1-3(u)(3)		weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 4/25/2025	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) A. Based on interview and record review, the facility failed to ensure the attending physician and family were notified in a timely manner of a significant weight loss in less than 30 days for 1 of 2 residents reviewed for gastric feedings. (Resident G) B. Based on interview and record review, the facility failed to ensure the attending physician and family were notified in a timely manner of a new open area to a resident's neck for 1 of 2 residents reviewed for notification of change in condition. (Resident D) Findings include: A. During an interview on 4-1-25 at 3:56 p.m., with a family member of Resident G, she indicated during the previous night, she had spent the night in Resident G's room, at his request. She explained Resident G had several strokes during 2024, resulting in significant paralysis and an inability to swallow safely, thus causing him to require a	F 0580	F 580 – notification of changes to family and physician. It is the intent of this facility is to ensure all proper notifications are made in relation to a resident's change in condition. 1. What corrective action will be accomplished by the resident found to have been affected by the deficient practice? Resident D's family and physician were notified of the open area on the neck on 3/24/2025. Resident G no longer resides in the facility. 2. 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 will have completed an audit on the residents with a wound for	04/25/2025

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	"feeding tube." The clinical record of Resident G was reviewed on 4-2-25 at 1:46 p.m. His diagnoses included, but were not limited to, encephalopathy, cerebral infarction with hemiplegia and hemiparesis affecting the right side, general muscle weakness, diabetes, gastrostomy (feeding tube) status. His re-admission Minimum Data Set (MDS) assessment, dated 3-5-25, indicated he was severely cognitively impaired, did not receive oral nutrition, and received 51 or more percent (%) of his nutrition from enteral feedings and received over 500 milliliters of enteral nutrition daily. It indicated his most recent weight was 205 pounds but did not indicate if this was reflective of any weight gain or weight loss. A review of Resident G's physician orders, effective 2-17-25, indicated he was to receive an enteral feeding of (brand name of liquid nutrition) of 60 milliliters (2 tablespoons) per hour, for a total of 1,440 milliliters every 24 hours. It also indicated he was not to receive anything by mouth. An order dated, 1-7-25, indicated to obtain his weight upon admission, then weekly for four weeks, then to obtain his weight monthly on Mondays. Resident G's initial weight, on 1-7-25, was recorded as 220.6 pounds, followed by a weight on 2-17-25, of 236.0 pounds, then a weight on 3-4-25, of 205.3 pounds. This reflected a significant weight loss of 30.7 pounds or more than 10% in less than one month. His clinical record indicated Resident G had been hospitalized from 2-1-25 to 2-17-25, and from 2-20-25 to 2-28-25. An interdisciplinary notation, dated 3-5-25, indicated Resident G had been recently readmitted to the facility and received "tube feedings." It		physician and family notification by 4/18/2025, any notification not done was completed on 4/18/2025. The DON/Designee will have completed a 30 day look back of residents with a weight loss and notified the physician and family as needed by 4/23/2025. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/Designee in-serviced the nursing staff on notification of family and physician for a change in condition to include a weight loss and a new wound. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/od disciplined as indicated. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON/Designee will review progress notes for change in condition and notification of family and physician five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will	

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	reflected a weight of 205.0 pounds, but did not reflect any weight loss or gain. It indicated his "Food Intakes," as "Fair." and he received enteral feedings at 60 milliliters per hour. It did not indicate he was to be, "NPO [nothing by mouth]." It indicated his physician, and family had been notified of this information. A second interdisciplinary notation, dated 3-12-25, with an updated weight of 206.0 pounds, on 3-11-25, provided the same information. The interdisciplinary team notations failed to identify the significant weight loss until a notation from "dietary," on 2-19-25, indicated, " triggering for sig wt [significant weight] gain 5% x 30 days- not of concern at this time, likely due to previous tube feed + [plus] oral intakes. Further wt gain not recommended. Cont [Continue] to monitor weekly on swat [interdisciplinary team]." Specific documentation failed to reflect the attending physician or family had been notified of the significant weight loss on the above dates. A notation, dated 3-26-25, from the Registered Dietitian (RD), indicated Resident G's current weight of 208.5 pounds was a significant weight loss of 5% in a 30 day period. It identified a concern of the accuracy of the documented weight obtained, on 2-17-25, as well as changes made to the resident's enteral feeding orders, which had been at a higher rate previously. The notation indicated the plan of action was to continue to monitor Resident G in the weekly interdisciplinary meetings, related to the enteral nutrition. This notation did not reflect the attending physician, or family had been notified of the significant weight loss on this date. In an interview with the Director of Nursing (DON) on 4-2-25 at 2:02 p.m., he indicated		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. 5. By what date the systemic changes for each deficiency will be completed? Date: 4/25/2025	

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	Resident G was followed by the interdisciplinary team on a weekly basis due to receiving tube feedings. He indicated the RD was aware of Resident G's weight loss. B. The clinical record of Resident D was reviewed on 4-1-25 at 11:01 a.m. It indicated his diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, metabolic encephalopathy, tracheostomy status and dysphagia. His most recent Minimum Data Set (MDS) assessment, dated 1-25-25, indicated he was severely cognitively impaired, was nonverbal, nonambulatory, and was dependent on staff for all activities of daily care. It indicated he had a feeding tube and a tracheostomy (trach), which required oxygen support and tracheostomy care, including suctioning. It indicated he did not have any pressure ulcers, but did have an open area to his feet and moisture associated skin damage. In an interview on 4-2-25 at 12:30 p.m., with a family member of Resident D, she indicated, "I was in on 3-23-25 for a visit and I did not see any problems with his skin. The next day, at his radiology appointment, I saw there was something on his neck. He does lean his head to the left a lot of the time...My guess is the trach collar elastic may have contributed to the place on his neck." She indicated he was taken directly to the emergency room (ER) after his radiology appointment for further treatment and evaluation. The family member indicated she had not been made aware of any skin concerns prior to noticing the open area to his neck at the radiology appointment on 3-24-25. She estimated the time of the radiology appointment was mid to late morning. She indicated she did not see a dressing or steri-strips to the open area, but there was some bloody drainage present to the trach tube			

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	ties and to the linen around/under the neck area. A review of the clinical record indicated a "Weekly Skin Check" form, dated 3-24-25 at 8:39 a.m., indicated Resident D had a newly open area. An accompanying document, also dated 3-24-25 at 8:39 a.m., entitled, "Weekly Wound Event," indicated a new "laceration," had been identified on that date to the left side of his neck, measuring 5.1 centimeters (cm) by 0.1 cm with a depth of 0.2 cm. It indicated a small amount of serosanguinous (combination of clear fluid and blood) drainage. It listed only "steri strips" as the current treatment. It indicated, on 3-24-25, the attending physician was aware and the responsible party "updated on wound status." The clinical record documentation failed to identify when the open area was initially identified and what treatment, if any, was conducted prior to the "Weekly Skin Check" being conducted. The nursing progress notes failed to identify any notifications to the facility administration of the new open area and the time of Resident D's departure from the facility to the radiology appointment. The DON indicated, on 4-1-25 at 11:35 a.m., he would provide a copy of the emergency room visit of 3-24-25, but did not provide the documentation prior to exit on 4-2-25. In an interview with the DON on 4-2-25 at 10:05 a.m., he indicated the nurse on duty for the night shift, of 3-23-25 until the morning of 3-24-25, had notified him, on 3-24-25, close to 7:00 a.m., that a new open area to the left side of Resident D's neck had been identified about an hour earlier and had cleaned it up and covered it with a dressing. "I told them that was fine and that I would have the wound nurse look at it as soon as she got there that morning. I went in with the wound nurse			

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	myself and that's when we found the laceration. It looked like the elastic from the trach mask had kind of cut into his neck. We cleaned it up and tried to pad it good with gauze squares." The DON indicated he did not see any documentation from the nurse who originally identified the open area and had made him aware of the situation, but the wound nurse documented her findings shortly thereafter. On 4-2-25 at 4:18 p.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for Notification of Change in Resident's Condition/Status/Treatment," dated 6-29-2024. It indicated, "It is the intent of the facility to ensure that the resident, their attending physician, and the resident's Responsible Party/POA are notified of changes in the resident's condition, status or treatment. This notification will be done promptly in order to obtain any orders needed for appropriate treatment and/or monitoring related to the change--as well as to promote the resident right related to make choices about treatment and care preferences...Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments--related to the notification. Notification is provided to the resident and/or the resident's Responsible Party/POA in conjunction with the resident right to make choices about care and treatment and to keep them informed of the resident's current health status--related to the notification." This citation relates to Complaint IN00456622. 3.1-3(n)(2) 3.1-5(a)(3)			

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 of 5 residents reviewed for bathing and hygiene care needs. (Resident B) Findings include: The clinical record of Resident B was reviewed on 3-31-25 at 10:12 a.m. His diagnoses included, but were not limited to, pneumonia, unspecified cirrhosis of liver, unspecified abnormalities of gait and mobility, cognitive communication deficit and general muscle weakness. His admission Minimum Data Set (MDS) assessment, dated 12-12-24, indicated he was moderately cognitively impaired, required moderate assistance from staff for bathing or showering, and supervision from staff for hygiene care. In an interview with a family member of Resident B on 3-31-25 at 11:15 a.m., he indicated Resident B received very few showers while at the facility. A comprehensive care plan was not located in Resident B's clinical record for assistance with activities of daily living (ADL's) or specifically for bathing and hygiene care needs. In an interview on 4-1-25 at 9:40 a.m. with the Director of Nursing (DON), he indicated the facility did not have a care plan for this resident's ADL's. In an interview on 4-1-25 at 11:04 a.m. with the MDS Coordinator, she indicated, "It looks like I overlooked doing a care plan for ADL's, based on the admission MDS and the baseline care	F 0656	F656 Develop/Implement Comprehensive Care Plan What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, self-care, mental, and psychosocial needs that are identified in the comprehensive assessment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. The MDS or designee completed a facility wide audit to update all current resident's care plans related to ADL abilities What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The MDS Consultant educated the MDS Coordinator on 4/15/2025 on the care plan process.	04/25/2025

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	plan...The baseline care plan is done by the admitting nurse, usually on the same day they are admitted. It's based on what that nurse sees and is told initially. The Admission MDS is conducted within that first week or so while the nursing staff can actually see how well the new admission [resident] is doing and what I can assess while I am in the process of that first MDS assessment." On 4-1-25 at 12:01 p.m., the DON provided a copy of a policy entitled, "Baseline Care Plan Assessment/Comprehensive Care Plans," updated on 9-18-2018. This policy indicated, "It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of Admission...The Baseline Care Plan will be discontinued upon the completion of the Comprehensive Care Plan. The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the 'Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs..." This citation relates to Complaint IN00450054. 3.1-35(a) 3.1-35(b)(1)		Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively 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 “F656 – Develop and Implement Comprehensive Care Plan Audit” will be a full house audit of ADL care plan for current residents. Any ADL care plan missing will be documented on the audit worksheet and added to the resident’s comprehensive care plan. Going forward, any new admission or readmissions to the facility weekly, in addition to any OBRA MDS completed weekly will be audited for ADL care plan accuracy and completion x 12 weeks. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified, and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 4/25/2025	

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	155271	A. BUILDING 00 B. WING	04/02/2025

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on interview and record review, the facility failed to provide bathing and/or showering care for 1 of 5 residents reviewed for bathing and hygiene care needs. (Resident B) Findings include: The clinical record of Resident B was reviewed on 3-31-25 at 10:12 a.m. His diagnoses included, but were not limited to, pneumonia, unspecified cirrhosis of liver, unspecified abnormalities of gait and mobility, cognitive communication deficit, and general muscle weakness. His admission Minimum Data Set (MDS) assessment, dated 12-12-24, indicated he was moderately cognitively impaired, required moderate assistance from staff for bathing or showering and supervision from staff for hygiene care and it was "very important," for him to be able to choose what manner of bathing he received, such as tub bath, shower, bed bath or sponge bath. In an interview with a family member of Resident B on 3-31-25 at 11:15 a.m., he indicated Resident B received very few showers while at the facility. In an interview on 4-1-25 at 11:04 a.m., with the MDS Coordinator, she indicated "It looks like I overlooked doing a care plan for ADL's [activities of daily living], based on the admission MDS and the baseline care plan...The baseline care plan is done by the admitting nurse, usually on the same day they are admitted. It's based on what that nurse sees and is told initially. The admission MDS is conducted within that first week or so while the nursing staff can actually see how well the new admission [resident] is doing and what I	F 0677	F 677 It is the intent of this facility to provide Activities of Daily Living for bathing and hygiene care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident B no longer resides in 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 interviewed residents for bathing and hygiene preferences and will be updating the residents Activities of Daily Living Care Plan by 4/23/2025. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON or designee will have education completed by 4/23/2025 to the nursing staff relating to bathing and hygiene per residents preferences. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what	04/25/2025

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	can assess while I am in the process of that first MDS assessment." A review of Resident B's bathing records for 12/2024, indicated his "Bathing Choice Provided" was scheduled for Monday and Thursday evenings. It indicated he received three bed baths, one partial bath and no showers for the 25 days of December he was present in the facility. His bathing records for 1/2025, indicated his "Bathing Choice Provided" was scheduled for Monday and Thursday evenings. It indicated he received three partial baths and one shower in the 30 days of January he was present in the facility. The facility provided a copy of an "I Would Like To Know" form, also known as a grievance form. The form, dated 1-2-25, indicated the facility's Social Services Designee (SD) had documented on the form that Resident B had questions regarding what his shower schedule was. A response to this form, dated 1-2-25, indicated the concern was brought to the attention of the nursing department on the same date. It indicated the "Action Taken" included contacting the son of Resident B to inform him to explain, "the shower schedule/protocol...explained to son and resident that [name of Resident B] can take showers at his preferred times due to his level of independence...Shower given same day." The bathing documentation for 1-2-25, did not reflect bathing of any type was provided to Resident B. This citation relates to Complaint IN00450054. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B)		quality assurance program will be put into place. The DON/Designee will audit 10 random residents for bathing/showering and hygiene per residents' preferences and care plan weekly x 4 weeks, then 5 random residents 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; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 4/25/2025	
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	Based on interview and record review, the facility failed to ensure a resident receiving continuous enteral (gastric) feedings received feedings as ordered and a significant weight loss occurring in less than 30 days was identified and timely interventions related to the weight loss were conducted for 1 of 2 residents reviewed for gastric feedings. (Resident G) Findings include: During an interview on 4-1-25 at 3:56 p.m., with a family member of Resident G, she indicated during the previous night, she had spent the night in Resident G's room, at his request. She explained Resident G had several strokes during 2024, resulting in significant paralysis and an inability to swallow safely, thus causing him to require a "feeding tube." She indicated sometime between 2:00 a.m. and 4:00 a.m., on 4-1-25, the continuous feeding had run out and it had not been resumed prior to her leaving the facility later that morning at 8:20 a.m. She indicated the nursing staff informed her the reason the feeding was not resumed was because the needed feeding solution was locked in an office in the facility and was not accessible to the nursing staff. In an interview with the Director of Nursing (DON) on 4-2-25 at 9:45 a.m., he indicated he had not been made aware of any issues regarding Resident G's feeding being unavailable during the night shift on Monday night. In an interview with the DON, one hour later, he indicated he had attempted to reach out to the nurse who had been on duty during that time but had to leave a message for the nurse to return his call. In an interview with the DON on 4-2-25 at 3:05 p.m., he indicated the nurse had called back and confirmed	F 0692	F 692 Nutrition/Hydration Status Maintenance It is the policy of this facility to ensure residents receiving continuous tube feedings and a significant weight loss have timely interventions. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident G no longer resides in the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The DON/Designee will have completed a 30 day look back of weights and implemented interventions as needed by 4/23/2025. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The ADM/Designee completed an in-service with the RD and nursing on monitoring of weights and reporting weight loss to the dietitian and implementing interventions. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. How the corrective action will be monitored to ensure the deficient	04/25/2025

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	Resident G's feeding had run out at approximately 3:00 a.m., on 4-1-25, due to the feeding solution having been locked up and inaccessible to the staff. He indicated the feeding was resumed on 4-1-25 at 8:30 a.m. The clinical record of Resident G was reviewed on 4-2-25 at 1:46 p.m. His diagnoses included, but were not limited to, encephalopathy, cerebral infarction with hemiplegia and hemiparesis affecting the right side, general muscle weakness, diabetes, gastrostomy (feeding tube) status. His re-admission Minimum Data Set (MDS) assessment, dated 3-4-25, indicated he was severely cognitively impaired, did not receive oral nutrition, and received 51 or more percent (%) of his nutrition from enteral feedings and received over 500 milliliters of enteral nutrition daily. It indicated his most recent weight was 205 pounds, but did not indicate if this was reflective of any weight gain or weight loss. A review of Resident G's medication administration record, treatment administration record and the nursing progress notes did not indicate any interruptions of the enteral feeding had occurred on 4-1-25. A review of Resident G's physician orders, effective 2-17-25, indicated he was to receive an enteral feeding of (brand name of liquid nutrition) of 60 milliliters (2 tablespoons) per hour, for a total of 1,440 milliliters every 24 hours. It also indicated he was not to receive anything by mouth. An order dated, 1-7-25, indicated to obtain his weight upon admission, then weekly for four weeks, then to obtain his weight monthly on Mondays. Resident G's initial weight on 1-7-25, was recorded as 220.6 pounds, followed by a weight on 2-17-25, of 236.0 pounds, then a weight on 3-4-25, of 205.3 pounds. This reflected a significant weight loss of		practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will monitor weights weekly for changes and implementation of interventions x 6 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. 5. By what date the systemic changes for each deficiency will be completed. Date: 4/25/2025	

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	30.7 pounds of more than 10% in less than one month. His clinical record indicated Resident G had been hospitalized from 2-1-25 to 2-17-25, and from 2-20-25 to 2-28-25. An interdisciplinary notation, dated 3-5-25, indicated Resident G had been recently readmitted to the facility and received "tube feedings." It reflected a weight of 205.0 pounds, but did not reflect any weight loss or gain. It indicated his "Food Intakes" as "Fair" and that he received enteral feedings at 60 milliliters per hour. It did not indicate he was to be "NPO [nothing by mouth]." It indicated his physician, and family had been notified of this information. A second interdisciplinary notation, dated 3-12-25, with an updated weight of 206.0 pounds, on 3-11-25, provided the same information. The interdisciplinary team notations failed to identify the significant weight loss until a notation from "dietary", on 2-19-25, indicated " triggering for sig wt [significant weight] gain 5% x 30 days- not of concern at this time, likely due to previous tube feed + [plus] oral intakes. Further wt gain not recommended. Cont [Continue] to monitor weekly on swat [interdisciplinary team]." Specific documentation failed to reflect the attending physician or family had been notified of the significant weight loss on the above dates. A notation, dated 3-26-25, from the Registered Dietitian (RD), indicated Resident G's current weight of 208.5 pounds was a significant weight loss of 5% in a 30 day period. It identified a concern of the accuracy of the documented weight obtained, on 2-17-25, as well as changes made to the resident's enteral feeding orders, which had been at a higher rate previously. The notation indicated the plan of action was to			

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	continue to monitor Resident G in the weekly interdisciplinary meetings, related to the enteral nutrition. This notation did not reflect the attending physician, or family had been notified of the significant weight loss on this date. In an interview with the Director of Nursing (DON) on 4-2-25 at 2:02 p.m., he indicated Resident G was followed by the interdisciplinary team on a weekly basis due to receiving tube feedings. He indicated the RD was aware of Resident G's weight loss. He indicated missing several hours of the enteral feeding, on 4-1-25, could possibly be of concern. On 4-2-25 at 3:54 p.m., the DON provided a copy of policy entitled, "Guidelines for Enteral Feeding: Adult," dated 7-3-2023. This policy indicated its purpose was "To provide guidance to qualified licensed clinical staff in hanging and maintaining and managing and administering Tube/Feedings and Enteral Nutrition to residents...The nurse will review the order for type of formula, rate and advancement instructions, all associated orders. The formula will be retrieved from where it is stored until use in a clean/dry area and at the proper temperature for stability...Weigh the resident 3x weekly or as ordered (usually M-W-F) and record in the medical record..." On 4-2-25 at 4:18 p.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for Notification of Change in Resident's Condition/Status/Treatment," dated 6-29-2024. It indicated, "It is the intent of the facility to ensure that the resident, their attending physician, and the resident's Responsible Party/POA are notified of changes in the resident's condition, status or treatment. This notification will be done promptly in order to obtain any orders needed for			

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	appropriate treatment and/or monitoring related to the change--as well as to promote the resident right related to make choices about treatment and care preferences...Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments--related to the notification. Notification is provided to the resident and/or the resident's Responsible Party/POA in conjunction with the resident right to make choices about care and treatment and to keep them informed of the resident's current health status--related to the notification." 3.1-46(a)(1) 3.1-46(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to thoroughly document information regarding the identification of a newly identified open area and information regarding notification of a change in condition to the family regarding the new open area for 1 of 2 residents reviewed for tracheostomies (trach). (Resident D) Findings include: The clinical record of Resident D was reviewed on 4-1-25 at 11:01 a.m. It indicated his diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, metabolic encephalopathy, tracheostomy status and dysphagia. His most recent Minimum Data Set (MDS) assessment, dated 1-25-25, indicated he was severely cognitively impaired, was nonverbal,	F 0842	Tag# 842 Resident Records-Identifiable Information It is the policy of this facility to document a newly identified wound and notification of the family and physician of the change in condition. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: The DON/Designee completed the wound assessment for resident D on 3/24/2025 and notified family and physician on 3/24/2025. How other residents having the potential to be affected by the same deficient practices will be	04/25/2025

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	nonambulatory, and was dependent on staff for all activities of daily care. It indicated he had a feeding tube and a tracheostomy, which required oxygen support and tracheostomy care, including suctioning. It indicated he did not have any pressure ulcers, but did have an open area to his feet and moisture associated skin damage. In an interview on 4-2-25 at 12:30 p.m. with a family member of Resident D, she indicated, "I was in on 3-23-25 for a visit and I did not see any problems with his skin. The next day, at his radiology appointment, I saw there was something on his neck. He does lean his head to the left a lot of the time...My guess is the trach collar elastic may have contributed to the place on his neck." She indicated he was taken directly to the emergency room (ER) after his radiology appointment for further treatment and evaluation. The family member indicated she had not been made aware of any skin concerns prior to noticing the open area to his neck at the radiology appointment on 3-24-25. She estimated the time of the radiology appointment was mid to late morning. She indicated she did not see a dressing or steri-strips to the open area, but there was some bloody drainage present to the trach tube ties and to the linen around/under the neck area. A review of the clinical record indicated a "Weekly Skin Check" form, dated 3-24-25 at 8:39 a.m., indicated Resident D had a newly open area. An accompanying document, also dated 3-24-25 at 8:39 a.m., entitled "Weekly Wound Event," indicated a new "laceration" had been identified on that date to the left side of his neck, measuring 5.1 centimeters (cm) by 0.1 cm with a depth of 0.2 cm. It indicated a small amount of serosanguinous (combination of clear and bloody fluid) drainage. It listed only "steri strips" as the current		identified and what corrective action will be taken: The DON/Designee completed an audit of residents with wounds and verified documentation was completed for the assessment of the wound and notification of the family and physician 4/18/2025. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. DON/Designee will in-service nursing staff on completing a wound assessment upon discovery of a wound and notifying the family and physician on 4/23/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practices will not recur: DON/Designee audit progress notes five time a week for new open areas for completion of assessment and family/physician notification x 4 weeks then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any	

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	treatment. It indicated, on 3-24-25, the attending physician was aware and the responsible party "updated on wound status." The clinical record documentation failed to identify when the open area was initially identified and what treatment, if any, was conducted prior to the "Weekly Skin Check" being conducted. The nursing progress notes failed to identify any notifications to the attending physician, family or facility administration of the new open area and the time of Resident D's departure from the facility to the radiology appointment. The Director of Nursing (DON) indicated, on 4-1-25 at 11:35 a.m., he would provide a copy of the emergency room visit of 3-24-25, but it was not provided prior to exit on 4-2-25. In an interview with the DON on 4-2-25 at 10:05 a.m., he indicated the nurse on duty for the night shift, of 3-23-25 until the morning of 3-24-25, had notified him on 3-24-25, close to 7:00 a.m., that a new open area to the left side of Resident D's neck had been identified about an hour earlier and they had cleaned it up and covered it with a dressing. "I told them that was fine and that I would have the wound nurse go look at it as soon as she got there that morning. I went in with the wound nurse myself and that's when we found the laceration. It looked like the elastic from the trach mask had kind of cut into his neck. We cleaned it up and tried to pad it good with gauze squares." The DON indicated he did not see any documentation from the nurse who originally identified the open area and had made him aware of the situation, but the wound nurse documented her findings shortly thereafter. On 4-1-25 at 3:15 p.m., in an interview with the Corporate Nurse, she indicated the facility does		needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 4/25/2025	

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	not have a specific policy on documentation. This citation relates to Complaint IN00456622. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			