STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. BUILDING 00 B. WING	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

(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 a Recertification and State Licensure Survey. Survey dates: February 14, 15, 16, 17, and 20, 2023 Facility number: 000519 Provider number: 155571 AIM number: 100287230 Census Bed Type: SNF/NF: 38 NF: 2 Total: 40 Census Payor Type: Medicare: 5 Medicaid: 30 Other: 5 Total: 40 This deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 28, 2023.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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

Tyisha Wheeler | Administrator | 03/09/2023

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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	Based on observation, record review, and interview, the facility failed to develop and implement interventions to reduce the risk of falls for 1 of 3 residents reviewed for accidents, (Resident 93). This deficient practice resulted in a fall with a fracture requiring hospitalization. Findings include: During an observation, on 2/17/23 at 10:56 a.m., Resident 93's room included pressure alarms to his bed and recliner, and a floor mat beside his bed. The resident's clinical record was reviewed on 2/15/23 at 1:04 p.m. Diagnoses included, but were not limited to, non-displaced fracture of proximal phalanx of right ring finger, repeated falls and dementia. Current physician orders included the following: a. 2/4/23, non-weight bearing to right hand, elevate as tolerated. b. 2/4/23, monitor surgical incision to right hand 4th digit. c. 2/4/23, bed/chair alarm to be used at all times. d. 2/4/23, cleanse right elbow medial area open skin tear/surgical incision with wound wash, cover open area with thin layer of bacitracin, cover with non-adherent pad and wrap with gauze and secure with self-adhering wrap. e. 2/4/23, cleanse right elbow lateral area, open skin tear/surgical incision with wound wash, cover open area with thin layer of bacitracin (antibiotic), cover with non-adherent pad, wrap with gauze and secure with self-adhering wrap.	F 0689	This facility respectfully request consideration for a desk review due to the low scope and severity and only receiving one deficiency as part of the survey. p> This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #93 remains in the facility. Resident has had no further occurrences. Care plan has been reviewed and updated, as necessary, to reflect current fall prevention interventions. 2) How the facility identified other residents All residents identified at risk for falls, per the Fall Risk Review	03/15/2023

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	f. 2/15/23, remove sutures at this time to right arm. g. 2/14/23, cleanse skin tears to the top of back of head area with wound wash then apply thin layer of bacitracin. A 1/28/23 discharge/return anticipated MDS (Minimum Data Set) assessment indicated an unplanned discharge to an acute hospital. He required extensive assistance with bed mobility, transfers, to walk in room, with dressing, toilet use and personal hygiene. Since the prior MDS assessment, he had one fall with injury, except major injury and one fall with major injury. A progress note, dated 1/19/23 at 5:00 a.m., indicated he had an unwitnessed fall in his room. His roommate alerted staff of the fall. He was found sitting on the floor, with his back to the bathroom. A head to toe assessment had been completed, with skin tears notes to his right arm and a hematoma to his left forehead. An IDT (Interdisciplinary Team) progress note, dated 1/19/23 at 1:47 p.m., indicated maintenance had inspected floor alarm with loose wiring noted, and the floor alarm was replaced. An alarm was to remain in place and be utilized during hours of sleep for impaired safety during night time hours. A current fall risk care plan, initiated on 12/16/20 and revised on 1/20/23, indicated he was at risk for falls due to his condition and risk factors, arthritis, assistive device for mobility, confusion/forgetfulness, and he refused to use call light during the night to ask for assistance. Most falls occurred during hours of sleep, he had a slow shuffling gait, and forgot to use assistive device for walking. Interventions included, but		evaluation, have the potential to be affected. Thus, this plan of correction applies to those residents. The identified residents have care plans in place with measures implemented to prevent injury from falls. If a fall occurs and an immediate intervention is not implemented, the staff will start increased safety checks until the IDT reviews the fall and determines new interventions to be implemented. 3) Measures put into place/ System changes: All staff will be re-educated relative to Free of Accident Hazards/Supervision/Devices, including but not limited to, residents at risk for falls and preventative measures in place, and residents' need for increased supervision to be implemented for prevention post falls. A QAPI action plan has been initiated. 4) How the corrective actions will be monitored: The Director of Nursing (DON), or Designee will be responsible to complete the QA tool titled, "Fall Risk" (Attachment) monthly for all falls to ensure ongoing compliance. Fall Risk QA tool will	

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	were not limited to, alarm floor mat to be used at all times during hours of sleep and check functioning every shift (3/11/22) and floor alarm replaced (1/19/23). The fall risk care plan did not indicate new interventions/precautions had been developed or implemented after his fall on 1/19/23. A progress note, dated 1/24/23 at 3:39 a.m., indicated he had woken up at about 1:30 a.m. to got to the bathroom, setting off the alarm. He was assisted back to bed by staff, 15 minutes later he had once again set off the alarm by getting up and taking himself to the bathroom, then every 10-15 minutes for two hours he got up to go to the bathroom, setting off the alarm each time. His roommate complained of getting very little sleep. Other residents on the same hall also complained of getting woke up numerous times during the night. A progress note, dated 1/25/23 at 5:21 a.m., indicated the resident had been up and down, setting the alarm off several times, and waking his roommate. Other residents had also complained about getting woken up. He was assisted to the bathroom and brought to the lounge to watch television for a short time, then he demanded to go back to bed. He was up again a short time later, taking himself to the bathroom, and setting off the alarm. Staff attempted to educate him on dangers of getting up by himself, but he was unable to understand. A progress note, dated 1/26/23 at 2:10 a.m., indicated he had been up and down since 12:30 a.m., going to the bathroom repeatedly due to not remembering he had just been there. He became short and verbally abusive to staff, and the floor		be completed monthly until 100% compliance achieved for 3 consecutive months. Any identified issues will be immediately addressed with the responsible individual(s). Logs are reviewed/revised as needed during the monthly facility QAPI MEETING. Date of Compliance: March 15, 2023	

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	alarm was upsetting other residents. A progress note, dated 1/26/23 at 9:56 a.m., indicated the doctor had been updated about resident getting up throughout the night, sounding the alarm, and causing distress to other residents. Staff had encouraged activities throughout the day. A progress note, dated 1/27/23 at 3:41 a.m., indicated he had ben up numerous times to the bathroom, setting off the alarm and waking others. The resident declined suggestions to go to television lounge with another resident. A progress note, dated 1/27/23 at 11:46 a.m., indicated a new order to start melatonin (supplement sleep-aid) at bedtime and to monitor for effectiveness and any side effects. A progress note, dated 1/28/23 at 3:00 a.m., indicated staff responded to the alarm sounding, and assisted him to the bathroom. A progress note, dated 1/28/23 at 9:55 p.m., indicated staff responded to alarm sounding. Resident 93 was found sitting on the floor. Obvious injuries had immediately been noted to his right forehead and right elbow. He was assisted up per three staff and seated on side of his bed. His right hand, fourth digit was grossly deformed with what appeared as white bone protruding from back of his finger. An order received to send to the emergency room for evaluation and treatment. An IDT progress note, dated 2/4/23 at 12:15 p.m., indicated Resident 93 returned to the facility on 2/3/23 from the hospital with three surgical incisions, two to his right elbow and one to his			

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	right hand fourth digit, which was a distal inter-phalangeal joint dislocation. He had also been diagnosed with pneumonia during his hospital stay. A current care plan, created on 2/4/23 and revised on 2/14/23, indicated he was at risk for complications of healing of his surgical site to right arm and finger. Interventions included, but were not limited to, administer treatment as ordered and assess incision daily during treatment for signs or symptoms of infection (increased redness or warmth), pain, drainage or dehiscence. During an interview on 2/17/23 at 10:51 a.m., CNA 5 indicated the resident used to have a floor alarm, but now had a bed and chair pressure alarm. During an interview, on 2/17/23 at 10:58 a.m., LPN 7 indicated the resident had frequent falls and needed more assistance with care since he returned from the hospital. Review of an undated, current facility policy, titled "INCIDENTS/ACCIDENTS/FALLS," provided by the Director of Nursing on 2/20/23 at 11:26 a.m., indicated the following: "...11...Each fall needs a new intervention rolled out...." 3.1-45(a)(2)			