STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155202	A. BUILDING 00 B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

(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: September 24, 25, 26, 27, and 30, 2024 Facility number: 000109 Provider number: 155202 AIM number: 100266290 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 4 Medicaid: 51 Other: 12 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 18, 2024. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 18, 2024.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to ensure a reweight was completed for a resident with a significant weight change for 1 of 3 residents reviewed for nutrition (Resident 47). Findings include: Resident 47's record was reviewed on 9/26/24 at	F 0692	It is the intent of this facility to ensure re-weights are completed for residents with a significant weight change. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/18/2024

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

Jennifer Etienne | Administrator | 10/17/2024

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	10:48 a.m. The profile indicated the resident's diagnoses included, but were not limited to, vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), chronic pain syndrome (symptoms beyond pain alone, like depression and anxiety, which interfere with one's daily life), and need for assistance with personal care. A physician's order, dated 1/27/22 indicated to provide the resident a general diet, regular texture, and thin liquids. A quarterly Minimum Data Set (MDS) assessment, dated 8/21/24, indicated the resident had severe cognitive deficit, was on a therapeutic diet, and had both a 5% or more in 1 month or 10% or more in 6 months weight loss and weight gain documented. A care plan, dated 7/8/22, indicated the resident was at increased nutritional risk secondary to diagnoses of dementia and mild depression. Interventions included, but were not limited to, weigh the resident monthly and as needed. Review of the resident's 6-month weight history indicated the resident weighed 122.5 pounds (lbs) on 6/2/24 and had decreased to 111.5 lbs on 7/1/24. The resident's weight loss was 11 lbs or 8.98 percent (%). The weight history lacked documentation that the resident had been reweighed after the significant decrease in her weight was noted. A nutrition at risk (NAR) progress note, dated 7/4/24, indicated the resident was being monitored due to a significant weight loss. The resident had triggered for significant weight loss of 9.00% in		**practice:** DON/Designee notified of missed re-weight from 7/1/2024 on 7/10/2024. No new orders. **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 with a significant weight change have the potential to be affected. The DON/Designee completed a 90 day look back at weights for missed re-weights and notified MD as needed on 10/16/2024. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DON/Designee educated staff on the policy “Weights”, to include when to obtain a re-weight on 10/1/2024. 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 action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	the past 30 days. An order to receive house shakes (drinks which were fortified with essential vitamins, minerals, protein, and fiber to help support overall health and well-being) three times daily (TID) and add weekly weights to ensure weight stabilization. The note lacked documentation of any reweight of the resident being completed. A NAR progress note, dated 7/11/24, indicated a Registered Dietician (RD) follow-up for significant weight loss of 9.4% in 30 days, 7.9% in 90 days and 12.3% in 180 days. A 0.5% weight loss was noted since last review on 7/4/24 and was considered fairly stable. Recommended to continue with house shakes and weekly weights. The note lacked documentation of any reweight of the resident being completed. A NAR progress note, dated 7/17/24, indicated an RD follow-up for significant weight loss. The resident had triggered for an 8.1 % weight gain since recent weight loss. Possible weight inaccuracy related to wheelchair weighing would be confirmed through weekly weights. Recommended to continue with house shakes and weekly weights. The note lacked documentation of any reweight of the resident being completed. During an interview, on 9/26/24 at 3:45 p.m., Registered Nurse (RN) 7 indicated it was her understanding if a resident had a significant weight discrepancy from one weigh to another, the staff would reweigh the resident as soon as the discrepancy was discovered. The nurse would also assess the resident for any edema or anything else that may have caused the weight fluctuation. During an interview, on 9/26/24 at 3:48 p.m., RN 8		**into place:** The DON/Designee will monitor weights five a week x 4 weeks for weight loss requiring a re-weight, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months 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 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 will the systematic changes be completed:** October 18, 2024	

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	indicated the staff should reweigh any resident immediately if there was a significant discrepancy in a weight from one weight to another. On 9/26/24 at 3:20 p.m., the Director of Nursing (DON) provided a document, dated 4/2017, titled, "Weights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...Nursing will notify the dietician or designee of any significant weight changes...A reweight will be obtained and recorded for all significant weight changes...." 3.1-46(l)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure a pharmacy recommendation had been addressed in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 35). Findings include: Resident 35's record was reviewed on 9/26/24 at 9:40 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease late onset (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks that occurs after 65 years of age). A quarterly Minimum Data Set (MDS) assessment, dated 5/1/24, indicated the resident had severe cognitive deficit and received no scheduled or as needed (PRN) pain medication.	F 0757	**It is the intent of this facility to ensure pharmacy recommendations in a timely manner,** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Upon review it was noted that the recommended PRN medication was discontinued on 6/18/2024 for Resident #35 **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:**	10/18/2024

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	A quarterly Minimum Data Set (MDS) assessment, dated 8/5/24, indicated the resident's cognitive status was unable to be assessed and she received no scheduled or PRN medication. A care plan, dated 12/2/23, indicated the resident had the potential for pain. Interventions included, but were not limited to medications as ordered. A pharmacy recommendation, dated 2/12/24, indicated the resident had two PRN orders for acetaminophen (medication used to relieve pain and/or fever). The orders indicated to administer two 500 milligrams (mg) tablets of acetaminophen every 6 hours PRN and a second order to administer two 325 mg tablets of acetaminophen every 4 hours PRN. The recommendation was to discontinue one of the orders to prevent possible overdose. The form lacked documentation that the physician had addressed the recommendation and lacked a signature and date of when the physician had reviewed the recommendation. A pharmacy recommendation, dated 6/9/24, indicated a second notice that the resident's two PRN for the acetaminophen were still in the resident's physician orders. The physician documented that he agreed with the recommendation and had ordered the discontinuation of the administration of the two 500 mg tablets of acetaminophen every 6 hours PRN. The physician signed and dated the form on 6/18/24. A historical review of the resident's physician's orders indicated the medication had been discontinued on 6/18/24. During an interview, on 9/26/24 at 1:17 p.m., the Administrator (ADM) indicated the pharmacy recommendation, dated 2/12/24, had not been addressed by the Director of Nursing (DON) or		All residents with pharmacy recommendations have the potential to be affected. The DON/Designee completed a 90 day look back of pharmacy recommendations for current residents for follow up on 10/1/2024. Any concerns were addressed immediately by the MD. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Adm/Designee in-serviced the clinical leadership team (DON, ADON, MDS, SSD) for timely follow up on pharmacy recommendations on 10/1/2024. Additionally, any staff member the fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **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 DON/Designee will audit monthly the pharmacy recommendations for timely follow up x 6 months. If the facility is	

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	the physician. The Pharmacist had written the recommendation again on 6/9/24. This recommendation was addressed as required. She was not aware why the initial recommendation had not been addressed. Pharmacy recommendations were to be addressed as soon as they were received. On 9/26/24 at 2:50 p.m., the ADM provided an undated document titled, "Distribution of Medication Regimen Review Report," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: ...Each recommendation must be acted upon. Procedure: ...3. The report will be directed to the Director of Nursing. 4. The attending physician and/or Medical Director will document their review and response to the recommendation...directly on the medication regimen review form...." 3.1-48(a)(1)		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 will the systematic changes be completed:** October 18, 2024	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure adequate sanitation of drinking glasses, pitcher, and kitchen equipment for 2 of 2 kitchen observations, and failed to ensure snacks were served in a sanitary manner for 1 of 1 random snack distribution observation. Finding includes: 1a. On 9/24/24 at 9:53 a.m., during initial kitchen tour, a thick white cloudy substance was observed on the inside surface of a 2-gallon pitcher. The pitcher was used to make lemonade,	F 0812	**It is the intent of this facility to ensure adequate sanitation of drinking glasses, pitchers and kitchen equipment. And to ensure snacks are served in a sanitary manner.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/18/2024

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	juice, and or tea for the residents. A thick cloudy substance was observed on a sink in the kitchen. The white substance was noted on the faucet base and went down into the inside of the sink. During an interview, on 9/25/24 at 10:41 a.m., Resident 21 indicated the plastic glasses that come from the kitchen were filthy and he did not like to drink out of them. During an interview, on 9/26/24 at 11:54 a.m., the Dietary Manager indicated she was aware of the facility having an issue with lime deposits on the plastic glasses and the 3-compartment sink. They had checked the salt levels to make sure it was at the appropriate level. They had tried running bleach through the dishwasher and used a de-limer solution which had worked. The only way she had been able to remove the lime on the drinking cups was to have staff scrub each individual cup by hand and she did not have the staff to be able to do that. During an interview, on 9/27/24 at 8:53 a.m., Registered Nurse (RN) 7 indicated they have had issues in the past with lime deposits on the drinking glasses on the closed unit, but they had purchased new ones, and she hadn't noticed an issue lately. During an interview, on 9/27/24 at 9:00 a.m., Resident 6 indicated she had noticed a white cloudy substance on the drinking glasses, and it had been an issue for a while. During an interview, on 9/27/24 at 9:01 a.m., Resident 37 indicated she had noticed a white cloudy substance on the inside of the drinking glasses ever since she had been there. She indicated she had been at the facility for a few		The Dining Services Manager/designee delimed the dish machine and effected cups, pitchers, and sink 10/1/2024. No residents were identified for serving snack in a sanitary manner. **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 resident's have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The ADM/Designee educated the kitchen staff on proper cleaning of dishes to prevent lime build up on DATE. The DON/Designee educated staff on serving snacks in a sanitary manner, to include wearing gloves or using hand sanitizer on 10/1/2024. Additionally, any staff that fails to comply with the point of this in-service will be further educated and/or disciplined as indicated.	

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	weeks. During an interview, on 9/27/24 at 9:04 a.m., Resident 32 indicated she had noticed a white cloudy substance on the inside of the drinking glasses for as long as she could remember, and she thought it was because of the hard water. She indicated at home she would use vinegar water to treat it. 1b. On 9/27/24 at 10:50 a.m., during a second kitchen observation, a thick white cloudy substance was observed on the inside of several plastic drinking cups stored on 3 pallets full of drinking cups. The Dietary Manager held up two of the plastic drinking cups and both contained a thick white cloudy substance. During an interview, on 9/27/24 at 10:55 a.m., the Dietary Manager, indicated they tried to run a de-limer solution through the dishwasher once a week. She had considered purchasing glass cups if the lime did not come off the plastic cups. During an interview, on 9/27/24 at 10:56 a.m., Cook 13 indicated they needed to run the de-limer solution through the dishwasher again because the glasses were getting "bad." He indicated the de-limer was ran through about once or twice a month. During an interview, on 9/27/24 at 11:38 a.m., the Administrator indicated she had hard water at home, and she believed that was why they had issues with lime at the facility. During an interview, on 9/27/24 at 2:18 p.m., the Administrator indicated the kitchen had a schedule for the de-liming to be done twice a week. She indicated the cleaning list was check		**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 Dietary Manger/Designee will monitor for lime build up in the dishwasher and dishes five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. The DON/Designee will monitor for sanitary serving of snacks five times a week x 4 weeks, then 3 times a week for 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date will the systematic changes be completed:**	

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	marked as if it had been completed. During an interview, on 9/30/24 at 1:30 p.m., the Administrator indicated they had a service man come to the facility over the weekend to look at the dishwasher and he did not identify a concern with the equipment, but he did take a plastic glass from the facility to run some tests on it. She indicated she had not received a lab report yet from the company. On 9/27/24 at 12:00 p.m., the Administrator provided an undated document, titled, "Sanitizing Equipment and Food Contact Surfaces," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Employees shall sanitize equipment and food contact surfaces utilizing proper sanitizing solution ...3. Sanitizing solutions are changed in accordance with manufacturer instructions or when the become visibly soiled. In general, each should prepare fresh solutions ...." 2. During a random snack distribution observation, on 9/26/24 at 9:39 a.m., Activity Aide 14 was on the closed unit and was removing an oatmeal cream pie from its plastic packaging and removing the snack with her bare hands and handed one to a female resident. Activity Aide 14 proceeded to hand two other residents an oatmeal cream pies in the same manner as the first one. The activity aide was not observed using gloves or hand sanitizer during the observation. During an interview, on 9/27/24 at 9:35 a.m., Certified Nurse's Assistant (CNA) 15 indicated she would place on a pair of gloves when serving a resident a food item or use the plastic cover to hand the resident the item. The CNA indicated staff should not touch food with their bare hands.		October 18, 2024	

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	On 9/27/24 at 11:31 a.m., the Administrator provided a documented with a date of 4/2017, titled, "Food Safety and Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The facility will practice safe food handling and avoid cross contamination through proper use of gloves ...The Food and Nutrition Department Manager or designee will ensure that employees practice proper use of gloves ...Single-use gloves should be used, and bare-hand contact must be avoided when handling ready to eat food ...." 3.1-21(i)(3)			