STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

(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. This visit included the Investigation of Complaint IN00428278. Complaint IN00428278- No deficiencies related to the allegations are cited. Survey dates: May 13, 14, 15, 16, and 17, 2024 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 45 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 21, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission 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 06/04/2024. Facility respectfully requests a desk review.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each			

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

Brenda Darlien Alfrey | Executive | 06/03/2024

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	resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview, observation, and record review, the facility failed to ensure residents had the freedom and assistance to exercise their rights to go outside for fresh air for 6 of 6 residents interviewed about residents rights during the Resident Council group interview.	F 0550	F 550 Resident Rights/ Exercise Rights It is the policy of this facility to ensure residents had the freedom and assistance to exercise their rights to go outside for fresh air.	06/04/2024

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	Findings include: During a resident council group interview, on 5/15/24 at 1:15 p.m., 5 of 5 residents present indicated they wanted to be able to sit outside in the fresh air but were not permitted to do this as the facility was unable to find staff to supervise them. This concern was discussed at the previous meeting and the grievance form was filled out. Resident 38 indicated she felt like a prisoner in the facility and would like to sit outside alone and de-stress. The "Resident Council Meeting Minutes," dated 2/8/24 and provided by the Activity Director on 5/13/24 at 1:27 p.m., indicated the following concern: residents not being able to leave without responsible party and the staff were not taking residents out for smoke breaks at the scheduled times. No resolution was documented. The "Resident Council Meeting Minutes," dated 3/14/24 and provided by the Activity Director on 5/13/24 at 1:27 p.m., indicated the following concern: Residents had an open grievance about leave of absence (LOA) and smoking. The resolution documented on 3/29/24 was for the Ombudsman (a public advocate) to visit the facility on 3/29/24 to meet with residents about LOA and smoking. The "Resident Council Meeting Minutes," dated 4/11/24 and provided by the Activity Director on 5/13/24 at 1:27 p.m., indicated the following concern: Residents not being able to use courtyard. The resolution documented on 4/12/24 was that due to weather, patio time had not been added to the calendar and would be added for summer months.		1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident 38 was assessed by the SSD on 06.03.24, no negative outcome related to the cited practice. 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. All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. 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 Administrator in-serviced staff on 05.29.24 on residents' rights, and the expectation of residents' request to go outside weather permitting. Activity Director in-serviced on outside visits daily weather permitting 05.20.24. Policy reviewed and updated by the IDT Team. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be	

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	Review of a facility document titled "I Would Like to Know," dated 4/11/24 and provided by the Administrator on 5/16/24 at 1:30 p.m., indicated the following: Resident council members want to know about using the patio or courtyards. Review of a facility document titled "Internal Review of I Would Like to Know," dated 4/12/24 and provided by the Administrator on 5/16/24 at 1:30 p.m., indicated the following actions taken: Spoke with activity department due to residents need supervision and courtyard has to be accessed through the secure unit. The resolution indicated that due to weather, patio time had not been added to the calendar and would be added for summer months starting in May. Review of the May 2024 activity calendar on 5/17/24 at 11:46 a.m., which was provided by the Activity Director on 5/17/24 at 11:45 a.m., indicated "patio time" was added to three days during the month of May as follows: 5/6/24, 5/10/24, and 5/27/24. An observation of the outside areas of the facility, on 5/17/24 at 12:30 p.m., indicated the following: the front area included two small grass covered lawns, a front entrance covered by an awning, and a large parking lot running the length of the building. The smoking section at the rear of the building was not enclosed, there was a smoking shed and open grassy lawn areas. The courtyard outside the secured unit is enclosed. The secured unit required a code to gain and the courtyard was accessible through this secured unit. An e-mail communication from the Ombudsman, dated 5/15/24 at 3:53 p.m., indicated she had met with the resident council group to discuss the desire for some residents to smoke at their own		monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. Social Service / Designee will complete audits with 10 random residents and inquire about their outside visits, a week 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 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. 4 By what date the systemic changes for each deficiency will be completed. 6/4/202 Facility respectfully requests a desk review	

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	discretion. She explained the facility had a liberal smoking policy and since the courtyard was not enclosed, there was potential for residents to leave the premise while unattended. During an interview, on 5/16/24 at 12:18 p.m., Resident 38 indicated she had asked at the front desk to be allowed to sit outside alone. She was advised there was no staff available to sit with her. She indicated she stopped asking to go outside. Resident 38 was aware there was a courtyard outside the secure unit, but since she was not a resident on the secured unit, she was not allowed back there. During an interview, on 5/16/24 at 12:30 p.m., CNA 21 indicated she worked on the secured unit and would have to ask the management staff if a resident from the unsecured unit would be allowed to sit alone in the locked courtyard, since it had to be accessed through the unit. During an interview, on 5/16/24 at 12:30 p.m., LPN 22 indicated she worked on both the secured unit and the unsecured unit, but would need to ask the DON if a resident who resided outside of the dementia unit would be allowed to sit alone in the locked courtyard. An undated, current facility policy, titled "Resident Rights", provided by the Administrator, on 5/13/24 at 10:00 a.m., indicated the following: "...(1) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:...1. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the			

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	United States...." 3.1-3(a)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a wound treatment was completed as ordered by the physician for 1 of 3 residents reviewed for pressure injuries. (Resident 47) Finding includes: Resident 47's clinical record was reviewed on 5/14/24 at 4:21 p.m. Diagnosis included, peripheral vascular disease, heart failure, atrial fibrillation, type 2 diabetes mellitus, and encounter for palliative care. A physician's order, dated 5/5/24, included the following: every day shift, cleanse area to right side of back with wound wash or normal saline, pat dry, apply medi-honey (wound treatment) and	F 0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer It is the policy of this facility to ensure wound treatments are completed as ordered. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident 47 dressing was changed on 5/16/2024, by T .Hannah RN 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.	06/04/2024

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	collagen (wound treatment), and cover with bordered foam. This order was discontinued on 5/14/24. A current physician's order, dated 5/15/24, included the following: every day shift, cleanse area to right side of back with normal saline, pat dry, apply medi-honey, and cover with bordered foam for wound care. A quarterly Minimum Data Set (MDS) assessment, dated 4/12/24, indicated the resident was severely cognitively impaired. Rejection of care behaviors were not exhibited during the assessment period. The resident required supervision to roll left and right. He required maximal assistance for toileting and personal hygiene. The resident was dependent for transfers. He had a chronic disease that may result in a life expectancy of less than six months. He was at risk for pressure ulcers and did not have any unhealed pressure ulcers. Skin interventions included a pressure reducing device for this bed. A current care plan, dated 2/13/24 indicated the resident had a potential for skin breakdown. Interventions included provide pressure reducing mattress on the resident's bed (3/4/24) and staff were to observe skin treatment with each care interaction. A current care plan, dated 5/13/24, indicated the resident had a wound present on the right back and left gluteal fold. Interventions included administer medications per physician's order (5/13/24) and pressure reducing mattress (5/13/24). A wound note, dated 5/13/24, indicated the right back wound was a facility acquired unstageable		All residents with pressure ulcers had an audit completed on 05.27.24 to ensure that dressings were changed per order and TARS reviewed for accuracy of documentation, L. Potter RN Interim Director of Nursing 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 DON/Designee in-serviced the nursing staff on policies "Physician Orders" and "Non-Sterile Dressings" on 06.03.24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or 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. DON/designee will complete wound treatment audits 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 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	

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	(full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by deadened tissue) pressure injury acquired on 4/23/24. The measurements were 0.5 centimeters (cm) in length, by 0.5 cm in width, by 0.1 cm depth. During a wound observation on 5/16/24 at 2:39 p.m., RN 7 removed Resident 47's wound dressing to the right upper back. The dressing was dated 5/14/24 and had initials written on it. Minimal serous drainage was noted on the dressing, approximately the size of a dime. During an interview at the time of observation, RN 7 indicated the dressing was dated 5/14/24. The dressing change to the right upper back was due to be changed daily. Review of the May Treatment Administration Record (TAR) indicated the resident's dressing change to the right back was not completed on 5/8/24. The record indicated the treatment had been completed on 5/15/24, and was documented as completed by staff with different initials than those observed on the dressing dated 5/14/24 (RN 7). Review of the resident's hospice binder lacked information of dressing changes completed by hospice staff on 5/8/24 and 5/15/24. During an interview on 5/16/24 at 3:13 p.m., RN 7 indicated she had not worked on the 300 unit on 5/15/24 when the dressing was due to be changed. She had completed the resident's right upper back dressing change on 5/14/24. On the days when a QMA was assigned to the 300 unit medication cart, the 400 Unit nurse was assigned to do dressing changes on the 300 Unit and 400 Unit. If		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. 4 By what date the systemic changes for each deficiency will be completed. 6/4/2024 Facility respectfully requests a desk review	

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	the 400 Unit nurse was unable to complete all of the dressing changes, they were required to notify management so additional assistance could be arranged to complete all of the dressing changes. During an interview on 5/16/24 at 3:39 p.m., RN 7 indicated it was not appropriate to chart a dressing change was completed if it was not completed. If it was changed by the hospice staff or refused by the resident, the facility nurse should have selected other and made a notation of what happened with the resident's wound dressing change in the comments. During an interview on 5/16/24 at 5:17 p.m., the ADON indicated a wound dressing change should not have been documented as completed if it wasn't done. Wound dressings were required to have the nurse's initials as well as the date when the wound care was completed. She indicated the hospice note, dated 5/15/24, lacked indication the resident's wound dressing had been changed by hospice. Wound care should have been completed as ordered. A current facility policy, undated, titled "Non-Sterile Dressings," provided by the Corporate Nurse Consultant 3 on 5/16/24 at 5:49 p.m., indicated the following: "...Procedure: ... 20. Apply prescribed ointment and/or dressing per physician treatment orders... 25. Initial treatment Administration record...." 3.1-40(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to provide services as recommended by the Registered Dietitian to maintain acceptable parameters of nutrition for 1 of 3 residents reviewed for nutrition. (Resident 50) Finding includes: During an interview on 5/13/24 at 3:04 p.m., Resident 50 indicated she had lost some weight since she admitted to the facility. She received wound care to her buttock every day. She also received a juice supplement. Resident 50's clinical record was reviewed on 5/14/24 at 3:22 p.m. Diagnosis included, type 2 diabetes mellitus, depression, and generalized weakness. An order, dated 4/19/24, included a general diet, regular texture, thin liquids, and a nutritional juice.	F 0692	F 692 Nutrition/Hydration Status Maintenance It is the policy of this facility to provide services as recommended by the Registered Dietitian to main acceptable parameters of nutrition. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Fortified Potatoes were added to diet order on 5/16/2024 by the DON and added to the tray care by the dietary manager. Care plan updated to reflect weight loss and interventions on 5/24/2024 by the MDS nurse. 2 How other residents having the potential to be affected by the same deficient practice will be	06/04/2024

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	An order, dated 4/22/24, included mirtazapine (appetite stimulant) 7.5 milligrams (mg) tablet by mouth daily in the evening. An order, dated 4/22/24, included Zofran (anti-nausea) 4 mg tablet every six hours as needed. An order, dated 5/12/24, included fluoxetine hydrochloride (anti-depressant) 40 mg capsule by mouth daily in the morning. Review of the resident's weights were as follows: The resident weighed 138 lbs. (pounds) on 4/17/24. The resident weighed 137.7 lbs. on 4/23/24. The resident weighed 137.6 lbs. on 4/26/24. The resident weighed 125.4 lbs on 5/7/24. This was a 9.13% weight loss since 4/17/24. The clinical record lacked additional weight measurements. A quarterly Minimum Data Set (MDS) assessment, dated 4/24/24, indicated the resident had mild cognitive impairment. She required supervision for eating meals. The resident had an unstageable pressure ulcer and a surgical wound that were present on admission. Skin interventions included a pressure reducing device for the bed, pressure injury care, and surgical wound care. A current diet care plan, dated 4/20/24, indicated the resident was on a general diet, regular texture, and thin liquids. Interventions included, monitor meal consumption of all meals (4/20/24), offer substitutions when the resident consumes 50 %		identified and what corrective actions will be taken. The DON/Designee completed a 90 day look back of the Registered Dietitians recommendations and any concerns were addressed immediately on 05.30.24 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 Administrator in-serviced the Director of Nursing and Dietary Manager on reviewing and following up on the Registered Dietitians recommendations on 05.30.24. 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 practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will complete audits on Registered Dietitians recommendations 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 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	

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	or less of a meal (4/20/24), and serve the diet as ordered (4/20/24). The care plan lacked any indication of weight loss, weekly weights, or supplements. A dietary progress note, dated 4/19/24, indicated the resident was on nutritionally at risk (NAR) monitoring for admission and wounds. The resident would continue to be monitored with weekly weights and NAR. The Registered Dietitian was available as needed. A dietary progress note, dated 4/27/24, indicated the resident was on NAR monitoring for admission and wounds. The resident continued to be monitored with weekly weights and NAR monitoring. The Registered Dietitian was available as needed. A dietary progress note, dated 5/5/24, indicated the resident was on NAR monitoring for admission and wounds The resident was not eating much. The plan included a recommendation to add fortified potatoes to lunch and dinner. The resident continued to be monitored with weekly weights and NAR monitoring. A dietary progress note, dated 5/10/24, indicated the resident was on NAR monitoring for weight loss and wounds. The resident was not eating. The plan included a recommendation to add fortified potatoes to lunch and dinner. The resident continued to be monitored with weekly weights and NAR monitoring. The clinical record lacked implementation of the recommended fortified potatoes supplement for lunch and dinner and weekly weights.		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. 6/4/202 Facility respectfully requests a desk review	

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	During an interview on 5/16/24 at 4:43 p.m., the Dietary Manager indicated a conference call was held every Friday with the Registered Dietitian, Dietary Manager, DON, ADON, and the Administrator for their weekly NAR/Skin and Weight Assessment Team (S.W.A.T.). They discussed new admissions and residents with weight loss. Any recommendations from the Registered Dietitian were communicated in the meeting and sent in an email to the Dietary Manager, DON, ADON, and Administrator. The recommendations were typically implemented the same day they were received. The Dietary Manager also discussed the changes with the DON the same day recommendations were received so orders were placed in the electronic medical record by the nursing staff. During an interview on 5/16/24 at 5:29 p.m., CNA 9 indicated ordered weights triggered in the electronic tasks for CNAs to obtain. Weights were reported to the nurses to be documented in the electronic health record. At times, the nurse on duty reminded the CNAs which residents required weights. CNA 9 denied having problems with obtaining the scheduled weights during her shift each day. During an interview on 5/16/24 at 5:34 p.m., LPN 10 indicated residents with weekly weights had orders that triggered on the Medication Administration Record (MAR) when the weights were due. She believed this order also triggered a task for the CNAs. Additionally, she reminded the CNAs at the beginning of the shift of any residents who triggered to be weighed that day. Without an order entered, the weights would not trigger. Dietary recommendations, such as weights, were usually reported to the nurse by the Dietary Manager or Registered Dietitian so the			

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	orders could be entered. Weights were documented in the MAR or the weights section in the electronic record. Upon reviewing the resident's clinical record, LPN 10 indicated Resident 50's record lacked orders for weekly weights and fortified potatoes for lunch and dinner. The weights were not obtained weekly and the resident had significant weight loss since she admitted. The Registered Dietitian made recommendations on 5/5/24 and 5/10/24 that should have been ordered and implemented. During an interview on 5/17/24 at 12:13 p.m., the DON indicated new admissions were placed on NAR for four weeks. She met weekly with the Registered Dietitian and recommendations were discussed. The Interdisciplinary Team also met daily to review any new orders or new progress notes to catch any orders that were not implemented. Weekly weights and supplemental recommendations should have been implemented and completed according to the Registered Dietitian's recommendations. Dietary supplement orders were implemented the when the orders were placed in the electronic record. She was unable to explain why the resident's NAR recommendations were omitted and orders were not placed in the clinical record for implementation. During an interview on 5/17/24 at 12:30 p.m., the Dietary Manager indicated she had not received the resident's NAR recommendations prior to 5/10/24. She could not explain why the orders for the recommendations were not in the resident's clinical record. During an interview on 5/17/24 at 2:12 p.m., the Dietary Manager indicated the cooks referenced the individual meal tickets in order to know when			

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	supplements were required on residents' meal trays. Upon review of the resident's meal tickets for 5/5/24, 5/10/24, and 5/17/24, the meal tickets lacked the fortified potatoes meal supplement for lunch and dinner. She had failed to save the supplement changes to the resident's meal tickets when she received the recommendation on 5/10/24. As a result, the resident's meal tickets lacked the fortified potato supplement up to and including 5/17/24. During an interview on 5/17/24 at 2:27 p.m., the resident indicated she had not been receiving repeat items such as potatoes for lunch and dinner each day. She had received mashed potatoes and a hamburger for lunch on this date, but had been getting a variety of sides prior to this date for lunch and dinner. A current facility policy, undated, titled "S.W.A.T. PROGRAM [SKIN AND WEIGHT ASSESSMENT TEAM]," provided by the Administrator on 5/17/24 at 1:25 p.m., indicated the following: "...POLICY: It is the policy of this facility to assess the nutritional status of each resident. S.W.A.T. is designed to aggressively review and address those residents exhibiting significant weight change or skin breakdown. These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status...." A current facility policy, dated 7/24/23, titled "GUIDELINES FOR OBTAINING RESIDENTS' WEIGHTS," provided by the Administrator on 5/17/24 at 1:34 p.m., indicated the following: "...Purpose: Accuracy with weight measurement is essential for residents in the long-term-care setting. Weight measurement is used to calculate			

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	energy, protein, and fluid needs. Further, weight is an indicator of nutritional and health status and changes in weight can often indicate other medical changes... KEY POINTS FOR ASSURING WEIGHT ACCURACY... Weekly weights mean WEEKLY...." 3.1-46(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to provide meaningful, structured activities and/or an environment with available diversionary materials within the secured dementia care unit for 3 of 4 residents reviewed for dementia services (Residents 25, 7, and 42). Findings include: During a confidential interview, a resident representative indicated the activity calendar posted in the dementia unit was not followed. Often times, the residents simply sat and watched TV. What was offered was not always meaningful to the residents. When activities were held, staff did not always invite everyone on the dementia unit to attend. The facility completed Resident Matrix document, provided on 5/13/24 following the entrance conference, indicated 22 residents resided on the dementia unit.	F 0744	F744 Treatment / Services for Dementia It is the policy of this facility to provide meaningful structured activities and / or an environment with structured diversionary materials within the secured dementia unit. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Residents # 7, 25 and 42 were assessed by the SSD/Designee and no negative psychosocial issues related to the alleged deficient practice. 2 How other residents having the potential to be affected by the	06/04/2024

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	The May 2024 Memory Care Unit/Hope Springs activity calendar, which was posted on the wall of the unit, had no activity before 10:30 a.m. listed for Monday through Friday. The first activity on Saturday and Sunday was scheduled for 10:00 a.m. The activity calendar for 5/13/24 (Monday) to 5/17/24 (Friday) contained the following morning activities: 5/13/24 -Monday 10:30 a.m.-Sip and Chat 11:00 a.m.-Meditation Moments 11:30 a.m.-Daily Chronicle From the finish of the 11:30 to the 2:15 p.m. activity, no activities were scheduled. 5/14/24-Tuesday 10:30 a.m.-Morning Meet Up 11:00 a.m.- Timeless Trivia 11:30 a.m.-Daily Chronicle From the finish of the 11:30 to the 2:15 p.m. activity, no activities were scheduled. 5/15/24-Wednesday 10:30 a.m.-Sip and Chat 11:00 a.m.-Sweatin' to the Oldies 11:30 a.m.-Daily Chronicle From the finish of the 11:30 to the 2:15 p.m. activity, no activities were scheduled. 5/16/24-Thursday 10:30 a.m.- Morning Meet Up 11:00 a.m.- Move and Grove 11:30 a.m.-Daily Chronicle From the finish of the 11:30 to the 2:15 p.m. activity, no activities were scheduled. 5/17/24-Friday 10:30 a.m.-Sip and Chat		same deficient practice will be identified and what corrective actions will be taken. All residents that reside on the dementia unit have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the dementia unit. 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 Administrator/Designee in-serviced the activity department on DATE, to follow activity as posted on the Activity Calendar, providing diversionary materials, engaging with resident and the policy " Memory Springs". 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 practice will not recur, i.e what quality assurance program will be put into place. Activity audits 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months for staff engagement, diversionary materials, and activities completed per Activity Calendar. If the facility	

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	11:00 a.m.- BINGO 12:00 p.m.-Cookout An untitled and undated facility document, provided after the entrance conference on 5/13/24, indicated the facility served breakfast from 8:00 a.m. to 9:00 a.m. During an observation on 5/13/24 at 8:38 a.m., the dementia unit/Hope Springs had one (1) dependent resident seated in the common area-lounge/dining area/activity room. The television was on. There were no diversionary materials, such as books, magazines, games, toys, or manipulative sensory devices, in the common area or visible in any common area in the dementia unit. During observations on 5/15/24 from 9:41 a.m. to 11:21 a.m., the activity area/lounge/dining area was void of any diversionary materials such a books, toys, games, magazines, manipulative devices. The television in the lounge/dining area played "Little House on the Prairie" from 9:41 a.m. to 11:21 a.m. (1 hour and 40 minute period). The staff did not engage with the residents or discuss what they were watching. Residents came and left the area. The most residents at any one time watching the TV was three. On 5/15/24 at 10:26 a.m., Activity Aide 15 pushed a coffee cart through the area. He offered residents coffee and asked how they took their coffee. He did not converse with the residents nor encourage the residents to converse with each other, and went from the lounge to individual rooms offering coffee. He indicated to the residents that he was not there for a smoke break.		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. 6/4/2024 Facility respectfully requests a desk review	

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	On 5/15/24 at 10:27 a.m., Activity Aide 15 engaged one resident in a game of cards. He indicated he would help them wait for the smoking time. On 5/15/24 at 10:28 a.m., an unknown staff member told a small group of residents they could not smoke yet because staff were not available to supervise. At this time, residents began to pace about. Multiple residents sat in their room doorways or paced about until 11:07 a.m., when a smoking break was offered. On 5/15/24 at 10:55 a.m., Activity Aide 16 invited a resident and their family member to join the card game. This resulted in two residents and a family member playing cards. No other residents were invited. "Sweatin' with the Oldies" was scheduled for 11:00 a.m., but no activity was offered at this time. From 11:00 a.m. to 11:21 a.m.. the only observed activity offered was the TV on "Little House on the Prairie" and two residents engaged in cards. During observations of the Hope Springs Unit on 5/16/24 from 10:01 a.m. to 11:30 a.m., the activity area/lounge/dining area was void of diversionary materials such a books, toys, games, magazines, manipulative devices. On 5/16/24 at 10:01 a.m., one resident was seated in a dining chair with the chair back against the wall. Another resident was seated in a chair facing a table and blank wall. The TV was turned on and playing a "western" show. From 10:01 a.m. to 10:33 a.m., the TV played a western show. Staff did not engage the residents in conversation about the television program.			

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	The 10:30 a.m. scheduled activity "Morning Meet Up" was not offered. On 5/16/24 at 10:34 a.m., the sound went off the television. The sound returned at 10:35 a.m. Western shows continued on the television until 11:03 a.m. Residents came and went from the area during this time. On 5/16/24 at 11:03 a.m., Activity Aide 15 walked about the unit with the coffee cart. He offered the residents coffee. He did not engage in meaningful conversation, nor encourage the residents to converse with each other. On 5/16/24 from 11:03 a.m. to 11:16 a.m., the television continued to play a western program when the picture went out. The television continued without any picture from 11:16 a.m. to 11:30 a.m., when the TV began working again. The 11:00 a.m. scheduled activity "Move and Grove" was not offered. On 5/16/24 at 11:30 a.m., staff and residents began preparations to await the lunch meal. The 11:30 a.m. scheduled activity "Daily Chronicle" was not offered. 1. Resident 25 was observed either in their room or within the unit without purposefully activities or engaged in meaningful pursuits as follows: On 5/13/24 at 9:01 a.m., the resident was in their room in a recliner. Their feet were up. They were softly snoring. The room was quiet. The resident was not engaged in any diversionary pursuits.			

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	On 5/13/24 at 1:09 p.m., the resident was in their room in a recliner. They were speaking with a staff member who had entered their room. On 5/14/24 at 9:14 a.m., the resident was in their room in a recliner. The window blinds were open to slits allowing the room to be dimly lit. The resident was not engaged in any diversionary pursuits. On 5/15/24 at 9:43 a.m., the resident was in their room in a recliner. Their feet were up and their eyes were closed. The slats on blinds were open a little the room was dark. The resident was not engaged in any diversionary pursuits. On 5/15/24 at 10:20 a.m., the resident was awake and walked into the unit lounge. The TV was on in the lounge. No structured activity was occurring. No diversionary materials such as books, puzzles, or games were visible in the area. The resident looked around the area. They spoke to another resident, using that residents name. The resident appeared to look around the area. On 5/15/24 at 10:22 a.m., the resident walked to the nursing station and spoke to an unidentified staff member. The resident asked, "Where is everyone?" The staff member said "I think everyone went to room for nap." No activity or diversion was offered to the resident. The resident left the area and ambulated back to their room and sat in their recliner. On 5/15/24 at 11:02 a.m., the resident was in their room in their recliner snoring softly. The resident was not engaged in any diversionary pursuits. On 5/15/24 at 4:16 p.m., the resident was in their room in their recliner with their eyes closed and			

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	feet up. The resident was not engaged in any diversionary pursuits. On 5/16/24 at 2:25 p.m., the resident was in their room in their recliner. Their feet were up and they were softly snoring. The resident was not engaged in any diversionary pursuits. On 5/16/24 at 2:49 p.m., the resident was in their room in their recliner. Their feet were up and they were softly snoring. The resident was not engaged in any diversionary pursuits. On 5/17/24 at 11:06 a.m., the resident was in their room in their recliner. Their feet were up and they were softly snoring. The resident was not engaged in any diversionary pursuits. Resident 25's clinical record was reviewed on 5/15/24 at 10:11 a.m. Current diagnoses included, dementia with agitation, depression, anxiety, and delusional disorder. The Resident 25's activity participation records for April 2024 indicated the resident had attended zero activities in the morning during the month of April. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. The resident's May 2024 activity participation record for 5/1/24 to 5/16/24 indicated the resident had attended two morning activities in 16 days. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. A 4/6/24, annual, MDS assessment indicated the resident stated it was very important to listen to music, very important to be involved in their favorite activities, was very important to go			

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	outside in good weather, and was very important to be involved in activities with groups of people. A 4/15/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, usually understood others and was usually understood by others, and had displayed no maladaptive behaviors during the assessment period. The resident had the following current care plans related to purposeful activities and meaningful pursuits: A current, 2/9/24, care plan problem/need regarding depression. Approaches to this need included, "encourage activities of choice; provide monthly activity calendar." A current,2/13/24, care plan problem/need regarding exhibiting symptoms of depression. Approaches to this need included, "Encourage resident to participate in activities of choice." A current,10/2/23, care plan problem/need cognitive impairment and expressing preferences. Approaches to this need included, "Encourage participation in activities of interest." A current, 2/13/24, care plan problem/need regarding insomnia. Approaches to this need included, "Encourage resident to not take naps during the day." A current, 4/16/24, care plan problem/need regarding a risk for a mood decline relating to depression. Approaches to this need included, "Encourage out of room activities." A current, 5/13/24, care plan problem/need			

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	regarding being at risk for behavioral disturbances related to dementia. Approaches to this need included, "Offer activity of choice." A 5/1/24, psychiatry progress note indicated, "Depression: continued tearful episodes 4. Mood Changes: continued tearful episodes 5. Dementia: continue to monitor..." 2. Resident 7 was observed either in their room or within the unit without purposefully activities or engaged in meaningful pursuits as follows: On 5/13/24 at 9:03 a.m., the resident was in bed in their room. The room was dark. Their eyes were closed. On 5/13/24 at 1:09 p.m., the resident was in bed in their room. The room was dark. Their eyes were closed. The TV was on. On 5/14/24 at 9:16 a.m., the resident was in bed in their room. The room was dark. Their eyes were open and she looked around the room. The TV was on. On 5/15/24 at 9:44 a.m., the resident's door was closed. The resident was not visible anywhere on the unit. On 5/15/24 at 11:03 a.m., the resident's door was closed. The resident was not visible anywhere on the unit. On 5/15/24 at 4:17 p.m., the resident's door was closed. The resident was not visible anywhere on the unit. On 5/16/24 at 10:31 a.m., the resident was in bed in their room. The room was dark. Their eyes			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

(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
	were open and she looked around the room. The TV was on. On 5/16/24 at 2:25 p.m., the resident's door was closed. The resident was not visible anywhere on the unit. On 5/17/24 at 11:06 a.m., the resident was in bed in their room. The room was dark. Their eyes were open and she looked around the room. The TV was on. Resident 7's clinical record was reviewed on 5/15/24 at 10:24 a.m. Current diagnoses included schizoaffective disorder, schizoaffective disorder, anxiety, depression, obsessive compulsive disorder, and dementia. The resident's activity participation records for April 2024 indicated the resident had attended zero activities in the morning during the month. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. The resident's May 2024 activity participation record for 5/1/24 to 5/16/24 indicated the resident had attended one morning activity in 16 days. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. A 9/1/23, annual, MDS assessment indicated the resident considered it very important to be involved in their favorite activities. A 3/3/24, quarterly, MDS assessment indicated the resident was moderately cognitively impaired and displayed no maladaptive behaviors during the assessment period.			

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	The resident had the following current care plans related to purposeful activities and meaningful pursuits: A current, 2/6/19, care plan problem/need regarding their desire to be involved in activities of interest. Approaches to this need included, "Provide resident with cueing and direction to and from all desired group activities." A current, 3/5/24, care plan problem/need regarding depression. Approaches to this need included, "Encourage activities of choice..." A current, 1/18/23, care plan problem/need regarding a diagnoses of major depressive disorder. Approaches to this need included, "Provide the resident with a program of activities that is meaningful and of interest." A current, 3/27/24, care plan problem/need related to anxiety. Approaches to this need included, "Encourage out of room activities..." A current, 3/26/15, care plan problem/need regarding insomnia. Approaches to this need included, "Encourage resident to do more activities in the day." A current, 6/27/17, care plan problem/need regarding schizoaffective disorder. Approaches to this need included, "Redirect to activity of choice..." A 5/1/24 Psychiatric Progress Note indicated the facility needed to continue to monitor behaviors related to depression, anxiety, dementia, and schizoaffective disorder. 3. Resident 42 was observed either in their room or within the unit without purposefully activities			

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	or engaged in meaningful pursuits as follows: On 5/13/24 at 8:58 a.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were closed. The room was dim. They were not engaged in any diversionary activity. On 5/13/24 at 1:08 p.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were closed. The room was dim. They were not engaged in any diversionary activity. On 5/14/24 at 9:12 a.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were closed. The room was dim. They were not engaged in any diversionary activity. On 5/15/24 at 9:42 a.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were closed. The room was dim. They were not engaged in any diversionary activity. On 5/15/24 at 11:01 a.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were open. The room was dim. They were not engaged in any diversionary activity. On 5/16/24 at 10:29 a.m., the resident was in their room seated in their recliner, Their knees were drawn up. They had a blanket on their lap. Their eyes were closed. The room was dim. They were not engaged in any diversionary activity. Resident 42's clinical record was reviewed on 5/16/24 at 5:16 p.m. Current diagnoses included,			

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	dementia and depression. The resident's activity participation records for April 2024 indicated the resident had attended zero activities in the morning during the month of April. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. The residents May 2024 activity participation record for 5/1/24 to 5/16/24 indicated the resident had attended two morning activities in 16 days. The record did not indicate the resident was invited and refused to attend or was unavailable for any morning activities. An 11/28/23, annual, MDS assessment indicated it was very important for the resident to engage in their favorite activities, very important to go outside for fresh air, and very important to be involved in religious activities. A 5/7/24, quarterly, MDS assessment indicated the resident was severely cognitively impaired and did not display any maladaptive behaviors during the assessment period. The resident had the following current care plans related to purposeful activities and meaningful pursuits: A current, 2/22/23, care plan problem/need regarding depression. Approaches to this need included, "Encourage activities of choice..." A current, 4/26/24 , care plan problem/need regarding dementia. Approaches to this need included, "Redirect resident to activities..." A current, 5/14/25, care plan problem/need regarding confusion regarding dementia.			

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	Approaches to this need included, "Involve in low stress/ small group activities." A current, 2/22/23, care plan problem/need regarding a cognitive deficit related to dementia. Approaches to this need included, "Encourage activities." A, 5/1/24, Psychiatry Progress Note, indicated the resident needed monitored for dementia, depression, and insomnia. During a confidential interview, an employee indicated the activities on the Hope Springs/ Dementia Unit were seldom offered as scheduled. During mornings, the residents slept or watched TV. No structured activities were offered until after lunch. During an interview on 5/17/24 at 10:41 a.m., Activity Aide 15 indicated he usually arrived to work at 11:00 a.m. He mostly worked 11:00 a.m. to 5:00 p.m. The activity "Sip and Chat" was simply passing coffee and connecting with the residents. He had never done "Morning Meet Up". "Daily Chronicles" was reading from a newspaper-like sheet. He did not know if that particular activity had been offered that week. During an interview on 5/17/24 at 10:46 a.m., Activity Aide 14 indicated he usually began his shifts between 10:30 a.m. and 11:00 a.m. "Sip and Chat" was passing coffee to residents. In the main area, off the dementia unit, the residents might sit in the activity area and chat. The person leading this activities usually passed the coffee on both the main unit and the dementia unit. He generally did not work on the dementia unit. During an interview on 5/17/24 at 10:57 a.m., CNA			

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	16 indicated there were very few activities ever offered in the dementia unit before lunch. Someone passed coffee and turned on the TV. Most mornings, residents spent time in their rooms, napping or watching TV. When they offered activities in the afternoon, there seemed to be good participation. During an interview on 5/17/24 at 11:00 a.m., LPN 5 indicated there were not many activities offered on the dementia unit before lunch time. She believed it was so they could do morning care like showers. In the morning, someone turned on the TV or music. During an interview on 5/17/24 at 11:02 a.m., Housekeeper 17 indicated there were not many activities on the dementia unit before lunch. During an interview on 5/17/24 at 11:44 a.m., the Dementia Care Director, who was also the Activity Director, indicated the following: Activities on the dementia unit/Hope Springs did not begin until 10:00 a.m. or 10:30 a.m. each day. Activities were not offered before this time because she must attend morning meetings and clinical meetings. "Sip and Chat" and "Morning Meet up" were times when the residents and staff gathered together and socialized. Sometimes the same staff were responsible for doing the activity on both the dementia unit and outside long time care unit. This event should have been more than coffee passing. Typically, "Daily Chronicles" was reading a newspaper-type sheet about events on this date. Generally, there were no structured activities on Hope Springs until after lunch. She was very confused about activity attendance in the electronic clinical record and did not			

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	understand why no activities appeared to be offered on first shift during April 2024. In the morning, CNAs were supposed to offer meaningful pursuits to the residents on Hope Springs. She indicated she would provide documentation regarding the training CNAs had been offered regarding meaningful pursuits for residents residing on the dementia unit. At the time of exit on 5/17/24 at 3:25 p.m., no documentation regarding CNA training for offering meaningful pursuits for residents with dementia had been provided. An undated facility policy titled "Memory Springs," provided by Corporate RN Consultant on 5/17/24 at 2:04 p.m., indicated the following: "...We believe that the quality of life for our residents is enriched when their days are filled with meaningful and enjoyable structured activity. We believe that this activity serve as a powerful coping mechanism in times of fear and stress. ... Memory Springs provides structured specifically for functionally limited residents. Memory Springs offers rich sensory stimulation...." 3.1-37(a)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure controlled medication counts were completed and acknowledgements signed to account for controlled medications for 2 of 3 medication carts reviewed. (300 Unit and Hope Springs Unit medication carts) . Findings include: During an observation on 5/15/25 at 10:17 a.m., QMA 4 indicated she had not signed the 300 Unit Narcotic Count Sheets at the beginning of her shift on 5/15/24. Additionally, two narcotic shift counts with acknowledgments were incomplete on the 300 Unit Narcotic Count Sheets for shifts on 5/9/24. Offgoing and oncoming staff members	F 0755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records It is the policy of this facility to ensure controlled medications counts are completed and acknowledgements signed to account for controlled medications. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	06/04/2024

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	assigned to the carts should have both signed at the beginning and end of each shift. This was an opportunity to have missing medications when narcotic shift counts when acknowledgements were incomplete. Review of the 300 Unit Shift to Shift Narcotic Count Verification Log from 5/8/24 to 5/15/24 indicated a lack of the following information: 5/9/24 Day shift- Oncoming Shift Signature, 5/9/24 Evening shift - Offgoing Shift Signature, and 5/15/24 Day shift- Oncoming Shift Signature. During an observation on 5/15/24 at 10:33 a.m., LPN 5 indicated she had signed the Hope Springs Unit Narcotic Count Sheets for the current shift, but failed to ensure both the total sheet count and the total card/medication count was accurately written on the Narcotic Count Sheet prior to signing it at the beginning of her shift. She briefly looked at the total card/medication count number and signed it. The offgoing and oncoming staff member for the medication carts were required to ensure the counts were accurate during shift change when they signed the acknowledgement. Additionally, signatures were missing for Hope Springs Unit Narcotic Count Sheets on 5/14/24 and 5/11/24. The Hope Springs Unit Narcotic sheet count on 5/11/24 lacked record of a narcotic count. Review of the Hope Springs Unit Shift to Shift Narcotic Count Verification Log from 5/9/24 to 5/15/24 indicated a lack of the following information: 5/11/24 Night shift- Oncoming Shift Signature and count completion,		No residents were identified for this alleged deficient practice. 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. All medication carts/residents have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applied to all nursing staff. 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 DON/Designee in-serviced the nurses and qualified medication assistance on the policy “Controlled Substances” on 06.03.24. 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 practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will audit	

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	5/14/24 Night shift - Offgoing Shift Signature, and 5/15/24 Day shift- Accurate count completion. During an interview on 5/17/24 at 12:33 p.m., the DON indicated Narcotic Sheet Counts/acknowledgements should have been completed by both staff members at the beginning and end of their shifts or any time the keys for the medication cart leave their hands to another medication cart attendee. Both the oncoming and offgoing signatures should have been completed when the count was completed. A current, undated facility policy titled "Controlled Substances," provided by the Administrator on 5/17/24 at 1:25 p.m., indicated the following: "...Policy: To maintain individual records of receipt and distribution of all controlled drugs in sufficient detail to enable an accurate reconciliation. Controlled substance shall be securely stored and precautionary measures taken to prevent misuse... 7. ...The drug shall be counted by the nurse to maintain accuracy... 8. Change of shift counts will be conducted by authorized personnel to reconcile drug availability... 12. Periodically the DON shall conduct a drug reconciliation in order to determine if nursing personnel are adhering to facility policy...." 3.1-25(e)(2) 3.1-25(e)(3)		controlled medication count records for completeness and acknowledgements signed 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 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. 6/4/2024 Facility respectfully requests a desk review	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.			

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	(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following:			

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	(1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as			

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	specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of			

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	care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

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	physical, mental, and psychosocial well-being, as required at §483.24. Based on record review and interview, the facility failed to ensure complete and accurate communication records between the facility and a hospice provider for 1 of 1 resident reviewed for hospice services. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 5/16/24 at 10:23 a.m. Diagnosis included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, neoplasm of the left breast, and vascular dementia. A physician's order, dated 12/22/23, indicated to admit to hospice services. A hospice care plan, initiated 12/22/23, indicated admittance to hospice for left breast cancer. Interventions included the following: keep hospice CNA/nurse updated on any care changes (12/29/23), keep hospice notified of all transfers and discharges (12/29/23), notify Hospice nurse of any new orders and changes in condition (12/29/23). A significant change Minimum Data Set (MDS) assessment, dated 1/5/24, indicated Resident 4 received hospice services. A review of the facility hospice communication binder, on 5/16/24 at 3:00 p.m., indicated Resident 4 was admitted to hospice services on 12/21/23. The hospice "Plan of Care" document indicated the resident would receive skilled nursing services twice weekly for eleven (11) weeks by a registered nurse and hospice certified nursing aide (CNA)	F 0849	F849 – Hospice Services It is the policy of this facility to ensure complete and accurate communication records between the facility and hospice provider. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. DON/Designee obtained all hospice communication on 05.17.24 for resident #4. 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. DON audited all hospice binders for communication documentation with no other residents being affected by the alleged deficient practice on 5.27.24 3 What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. DON/Designee educated hospice companies on providing documentation of communication for each visit ON 06.04.24. 4 How the corrective	06/04/2024

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	services twice weekly for eleven weeks. The communication binder lacked a sign-in sheet for services provided. In the month of May 2024, the hospice binder contained one skilled nursing "Communication Note", dated 5/8/23. The hospice binder lacked CNA communication notes for the month of May '24. During an interview, on 5/16/24 at 4:41 p.m., RN 18 indicated the hospice communication books had log-in sheets for the hospice provider to utilize so the facility staff would know when the resident was visited. The hospice staff stopped at the nurses station and communicated to facility staff about the care provided at these visits. During an interview, on 5/16/24 at 4:46 p.m., the DON indicated the hospice communication binder was updated when the facility received documentation from the hospice provider, which was usually towards the end of each month. She indicated the hospice staff verbally communicated with facility staff at each visit about the care provided, but the communication binder should be kept current in order to keep clear communication between the facility and the hospice provider. A current contract with Resident 4's hospice provider, dated 6/23/22, provided by the Administrator, on 5/13/24 @ 10:00 a.m., indicated the following: "...5.1 Preparation and Maintenance of Records. The facility shall prepare and maintain medical records for each Hospice patient receiving services pursuant to the Agreement. The medical records shall consist of progress notes and clinical notes describing all inpatient services and events in accordance with the patients Plan of Care...."		action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will complete an audit on hospice communication documentation 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 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. Corrective action completion date: 6/4/2024. Facility respectfully request a desk review	

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	3.1-37(a)			