| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00431764 and IN00431926.<br><br>Complaint IN00431764 - No deficiencies related to the allegations were cited.<br><br>Complaint IN00431926 - Federal/State deficiency related to the allegation is cited at F842.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: April 24, 25, and 26, 2024<br><br>Facility number: 000138<br>Provider number: 155233<br>AIM number: 100266500<br><br>Census Bed Type:<br>SNF/NF: 61<br>Total: 61<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 46<br>Other: 13<br>Total: 61<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 3, 2024. | F 0000 | Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because federal and state law require it. Compliance has been and will be achieved no later than, the last completion date identified in the POC. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiency below is not an admission that the alleged facts occurred as presented in the statements. This report in its entirety has been reviewed by our quality Assurance Committee. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jalena Ball | Administrator | 05/15/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on interview, observation, and record review, the facility failed to ensure a resident did not sustain a skin injury during therapy for 1 of 2 residents reviewed for skin wounds. (Resident B)<br><br>Findings include:<br><br>During an interview on 04/24/24 at 9:37 A.M., Resident B indicated he was in the facility related to issues with his back. He participated in physical therapy. A few weeks ago, he was in therapy and his back was burned while he was using the TENS (Transcutaneous Electrical Nerve Stimulation) machine (a device that used low-voltage electrical current to help with pain). The therapist wasn't sure what happened and said the machine malfunctioned. They took the patch off his back, and it had burned the first layer of his skin. The Wound NP (Nurse Practitioner) came in every week to assess and treat the wound. The burn was pretty painful. The wound treatment used to be daily, but now they only have to change it every three days.<br><br>During an interview on 04/24/24 at 9:50 A.M., the DON (Director of Nursing) indicated the therapist was following the directions on the TENS unit. The resident was hooked up to the device and was doing some arm exercises. She thought the pad moved on the resident's skin with the resident's movement.<br><br>During an interview on 04/24/24 at 1:23 P.M., the | F 0684 | **F684 Quality of care**<br>It is the intent of this facility to ensure residents do not sustain a skin injury during therapy.<br>**What corrective actions will be accomplished for residents found to have been affected by the deficient practice-**<br>Resident B was assessed by the DON on 3/27/2024 and also assessed by the Wound NP on 4/3/2024, treatment orders are in place until resolved.<br>**How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken-**<br>A skin assessment was conducted on all residents receiving TENs unit services with no negative findings by the DON/Designee 3/2/2024<br>**What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur-**<br>At an in-service held for the therapy department on 04/05/2024 and by the Regional Manager for Select Rehab the following was reviewed: | 05/15/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | TDM (Therapy Department Manager) indicated he had used the TENS device five or six other times on the resident with no issues. He was familiar with the equipment; he wasn't sure what happened. There were four sticky pads that attached to the resident's skin in a criss cross fashion, with a lead wire attached to each pad. When using the machine, he would set the stimulation to an appropriate level and ask the resident to let him know when he felt the stimulation. He would adjust the level to as appropriate, so that it was high, but still comfortable. The machine ran for 15 minute cycles. The cycle was almost complete when the machine indicated "check pads" or something to that effect. Since the cycle was almost over, he just turned it off and went to remove the pad. When he saw the pad, it was not flat, but folded over on the resident's skin. The skin was burned where the pad was folded. The resident did not indicate he felt anything. The TDM indicated he had attached the sticky pads to the resident's back like he had done several times before. He did not think there was an issue with the machine, someone came out and inspected it once a year or so. He thought the device was fine, the pad was not on the resident properly. He put it on correctly, but it didn't stay that way.<br><br>The most recent invoice for the annual safety inspection of the TENS device was provided by the DON on 04/25/24 at 9:00 A.M. The invoice indicated the device was inspected on 11/14/22 and passed inspection with no concerns.<br><br>During an interview on 04/25/24 at 10:05 A.M., a representative from the device inspection company indicated when they inspected this type of device, they would check the voltage and the current, making sure levels were not too high or | | *Indications/Contraindications Monitoring for Electrical Stimulation Therapy<br>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.<br>**How the corrective actions will be monitored to be sure the deficient practice does not recur—i.e., what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed—**<br>An audit tool titled “F684” will be utilized by the Director of Therapy (DOT) and/or Designee to monitor residents utilizing the TENS unit for any contraindications, condition of leads and pads. DOT and/or designee will monitor residents receiving TENS treatment 5 days a week x 4 weeks, then 3 days a week for 4 weeks, and 1 day for a week for 4 months. If the facility is within 95% compliance at the end of 6 months, then monitoring can be stopped. Any concerns will be addressed immediately and discussed in QAPI monthly with actions plans developed as needed.<br><br>Date of Compliance: 05/15/2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | too low. They would make sure the leads weren't frayed. The device should be inspected annually.<br><br>The facility lacked documentation the TENS device had been inspected since 11/14/22.<br><br>The clinical record for Resident B was reviewed on 4/25/24 at 11:01 A.M. An Admission MDS (Minimum Data Set) assessment, dated 03/20/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, arthritis, spinal stenosis, and intervertebral disc displacement.<br><br>A Nursing Progress Note, dated 03/27/24 at 1:00 P.M., indicated the resident needed to be assessed. The resident was noted to have a burn on his lower back on the right side.<br><br>A Skin and Wound note, dated 04/24/24 at 12:40 P.M., indicated the wound was a second degree burn on the resident's lower back that was improving. The resident reported he was wearing a TENS unit in therapy and was burned. The wound measured 3.5 cm (centimeters) x 2 cm x 0.1 cm. 75-99% of the tissue was granulation tissue (pink-red moist tissue that fills an open wound, when it starts to heal) and 25-49% of the tissue was slough (non-viable tissue that was usually moist). The wound was derided, and the wound treatment orders were changed.<br><br>The resident's wound was observed with the DON on 04/25/24 at 11:09 A.M. The resident's call light was on. Upon entering the resident's room, he indicated the dressing had come off his wound. The soiled dressing was sitting on the over the bed table. A small amount of dried, bloody drainage was observed on the dressing. The resident's right lower back was observed. The | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | wound was oval shaped, approximately 3 cm x 2 cm. The wound bed was dark pink granulation tissue. There were no signs infection. The resident indicated the wound hurt and requested pain medication.<br><br>During an interview on 04/25/24 at 1:10 P.M., the TDM indicated you stay right there with a resident when using the TENS device. He didn't visually monitor the resident's skin the whole time when using the device, but he would probably look at residents' skin more often now.<br><br>The current, undated facility policy, titled "Low Voltage Electrical Stimulation ("E-Stim")" was provided by the DON on 04/25/24 at 11:40 A.M. The policy indicated, "...treatments will be administered by designated personnel under the supervision and direction of a licensed therapist according to the manner directed in the therapy evaluation/plan of care...The resident is to be positioned on a treatment table/mat or chair and draped appropriately for treatment..."<br><br>3.1-37(a) | | | |
| F 0842<br>SS=E<br>Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. | | | |
| | Based on interview and record review, the facility failed to ensure resident medication administration records accurately reflected the administration of narcotic pain medication for 4 of 6 residents reviewed for medication administration. (Residents B, D, G, and H).<br><br>Findings include:<br><br>1. The clinical record for Resident B was reviewed on 4/25/24 at 11:01 A.M. An Admission MDS (Minimum Data Set) assessment, dated 03/20/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, arthritis, spinal stenosis, and intervertebral disc displacement. The resident's physician's orders included, but were not limited to, an open ended order, with a start date of 03/11/24, for Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every eight hours as needed for pain.<br><br>The Controlled Drug Receipt/Record/Disposition Form for the Hydrocodone-Acetaminophen 5-325 | F 0842 | F842 Resident Records-Identifiable Information<br>It is the policy of this facility to ensure residents medication administration record accurately reflects the administration of narcotic pain medications.<br>**What corrective actions will be accomplished for residents found to have been affected by the deficient practice-**<br>Resident B, G, and H still reside in the facility. Resident D no longer resides the facility.<br>Residents were assessed for pain and skin assessment completed, physician notified and review of narcotic logs completed by the DON/Designee on March 17-20, 2024<br>**How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective** | 05/15/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | mg medication indicated the medication was signed out as given on the following dates and times:<br><br>- 03/16/24 at 6:00 A.M.,<br>- 03/16/24 at 2:00 P.M.,<br>- 03/17/24 at 6:00 A.M., and<br>- 03/17/24 at 2:00 P.M.<br><br>The March 2024 EMAR (Electronic Medication Administration Record) lacked documentation of the medication was administered on the above dates and times.<br><br>2. The clinical record for Resident D was reviewed on 4/25/24 at 11:20 A.M. An Admission MDS assessment, dated 02/23/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure and polyneuropathy. The resident's physician's orders included, but were not limited to, an open ended order, with a start date of 02/15/24, for Hydrocodone-Acetaminophen 7.5-325 mg every six hours as needed for pain.<br><br>The Controlled Drug Receipt/Record/Disposition Form for the Hydrocodone-Acetaminophen 7.5-325 mg medication indicated the medication was signed out as given on the following dates and times:<br><br>- 02/18/24 at 1:30 P.M.,<br>- 03/05/24 at 6:00 A.M., 12:00 P.M., and 4:30 P.M.,<br>- 03/08/24 at 11:00 P.M.,<br>- 03/11/24 at 6:00 A.M., 1:00 P.M., and 5:00 P.M.,<br>- 03/14/24 at 10:00 P.M.,<br>- 03/16/24 at 6:00 A.M., and<br>- 03/17/24 at 8:00 A.M.<br><br>The March 2024 EMAR lacked documentation of | | **action will be taken-**<br>All Residents receiving narcotics for pain have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. All resident's receiving narcotics were audited on March 20, 2024<br>**What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur-**<br><br>Licensed nursing staff was educated on March 27th and March 28th 2024 , by Pharmacist from United Rx on "Medication Administration" to also include the Controlled Substance Disposal, Discrepancies, Dispensing and documenting, Delivery of controlled substance and shift counts. The DON/Designee educated/re-educated nursing staff on administering controlled medications and signing the EMAR with each administration on April 29, 2024. Additionally, any staff that fails to comply to the points of this in-service will be further educated and/or disciplined as indicated.<br>**How the corrective actions will be monitored to be sure the deficient practice does not recur—i.e., what quality assurance program will be put into place and by what date** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | the medication was administered on the above dates and times.<br><br>3. The clinical record for Resident G was reviewed on 4/25/24 at 11:26 A.M. A Quarterly MDS assessment, dated 01/12/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes and kidney disease. The resident's physician's orders included, but were not limited to, an open ended order, with a start date of 02/26/24, for Tramadol (a narcotic pain medication), 50 mg every six hours as needed for pain.<br><br>The Controlled Drug Receipt/Record/Disposition Form for the Tramadol 50 mg medication indicated the medication was signed out as given on the following dates and times:<br><br>- 04/04/24 at 2:00 A.M.,<br>- 04/05/24 at 1:10 A.M., and<br>- 04/12/24 at 9:00 A.M.<br><br>The April 2024 EMAR lacked documentation of the medication was administered on the above dates and times.<br><br>4. The clinical record for Resident H was reviewed on 4/25/24 at 10:26 A.M. An Admission MDS assessment, dated 03/02/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hip fracture, and seizure disorder. The resident's physician's orders included, but were not limited to, an open ended order, with a start date of 02/26/24, for Oxycodone (a narcotic pain medication) 10 mg every six hours as needed for pain.<br><br>The Controlled Drug Receipt/Record/Disposition | | **the systemic changes for each deficiency will be completed—** Audit tool entitled “F842” will be utilized by the DON and/or designee, will audit 6 random residents five days a week for four weeks, 6 random residents three days a week for four weeks, then 6 random residents weekly for four months. If a 95% compliance rate is achieved, then audits maybe stopped. Any concerns will be addressed immediately and discussed in monthly QAPI and actions plans developed as needed.<br>5/15/2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. BUILDING 00<br>B. WING | 04/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF BATESVILLE, THE | 958 E HWY 46<br>BATESVILLE, IN 47006 |

| (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 |
|---|---|---|---|---|
| | Form for the Oxycodone 10 mg medication indicated the medication was signed out as given on the following dates and times:<br><br>- 02/15/24 at 6:00 P.M.,<br>- 02/16/24 at 12:00 A.M., 6:00 A.M., and 6:40 P.M.,<br>- 02/17/24 at 6:00 A.M.,<br>- 02/22/24 at 9:30 P.M.,<br>- 02/23/24 at 4:00 A.M.,<br>- 02/24/24 at 6:00 P.M.,<br>- 02/25/24 at 5:00 A.M.,<br>- 02/27/24 at 8:00 P.M., and<br>- 03/02/24 at 8:00 P.M.<br><br>The February and March 2024 EMARs lacked documentation of the medication was administered on the above dates and times.<br><br>During an interview on 04/26/24 at 1:42 P.M., RN 2 indicated when a nurse administered a controlled medication it would be documented in the computer EMAR and on the paper controlled medication count sheets in the binder on the medication carts.<br><br>The current facility policy, titled "MEDICATION ADMINISTRATION", dated February 2017, was provided by the Director of Nursing on 04/26/24 at 10:28 A.M. The policy indicated, "...administer all medications safely and appropriately...return to medication cart and document medication administration with initials in appropriate spaces on Medication Administration Record (MAR)..."<br><br>3.1-50(a)(1)<br>3.1-50(a)(2)<br><br>This citation relates to Complaint IN00431926. | | | |