STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 E STATE BLVD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 10, 11, 14, 15 and 16, 2023. Facility number: 000214 Provider number: 155321 AIM number: 100267240 Census Bed Type: SNF/NF: 40 Total: 40 Census Payor Type: Medicare: 1 Medicaid: 38 Other: 1 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complaeted August 24, 2023	F 0000	Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: September 1, 2023. **Facility is respectfully requested paper compliance for all deficiencies in this POC.**	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Smith	HFA/RDO	09/08/2023

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

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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review the facility failed to ensure communication of code status for 1 of 3 residents reviewed. (Resident 37) Findings include: Resident 37's record review, began on 8/10/23 at 1:55PM, diagnoses included Alzheimer's disease,	F 0578	**F- 578** It is the policy of the facility to ensure communication of residents code status changes are provided timely. Resident 37's code status change was updated and care plan	09/01/2023

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	epilepsy, and weakness. Resident 37 had an active order of full code (to have Cardiopulmonary Resuscitation) dated 4/3/23. The current quarterly comprehensive assessment indicated a BIMS (Brief Interview Mental Status) score of 99. The score of 99 indicated severe cognitive impairment. Resident 37's comprehensive care plan indicated she was a full code. Resident 37's face sheet indicated she was a full code. During an interview on 8/14/23 at 7:13 AM RN 6 indicated she relied on information from shift change report and electronic medical record to include: face sheet, orders, and care plan to provide person centered care to residents. During an interview, on 8/14/23 at 9:32 AM, the DON (Director of Nursing) indicated resident should have an order and care plan regarding current code status in the medical record. The DON indicated they refer to orders and face sheet for code status. The DON indicated she would investigate current code status of full code. On 08/15/23 at 10:11 AM, an order for DNR (Do not Resuscitate) was entered. On 8/16/23 at 9:04AM the Administrator provided a preference for DNR status signed by Resident 37's husband on 8/8/23. The Administrator further provided a care plan with the focus of DNR code status. The date initiated was 4/16/23 with revision on 8/14/23. In an interview on 8/16/23 at 9:28 the DON indicated she updated the previous care plan of full code to accurately reflect DNR. She indicated		updated correctly by the facility on 8/15/2023. All Residents who reside in the facility have the potential to be affected by this finding. A complete audit was completed by the ADON to ensure that all residents had an active code status order At an in-service for all staff held by the Administrator on 8.31.23 the following was reviewed: 1. Advanced Directives Policy and Procedure Any staff who fail to comply with he points of the in-services will be further educated and/or progressively disciplined as indicated. The DON/Designee will review the 24 hour report 5 times daily in morning meeting to ensure all code status changes are updated and careplanned as appropriate. This monitoring will continue for a minimum of 6 months, until 100% compliance, and then weekly ongoing. At the monthly QAPI meeting, the monitoring of the Code Status Change audits will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the	

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	she possibly should have resolved the previous code status focus in the care plan and started a focus on the DNR status to make clear the resident husband's choice of code status. On 4/16/23 Resident 37 was a full code. Resident 37's code status should have changed when a new preference form (post) was signed by the husband on 8/8/23. If Resident 37 would have had a cardiovascular event the facility would have performed CPR between the dates of 8/8/23 and 8/15/23 when the correct code status was entered. A policy titled, Directives Policy and Procedure" was provided by the Administrator on 4/16/23 at 9:04AM, the last revision date of policy was 6/2020. The policy indicated Procedure: 5. The resident desires will be re-evaluated on an annual basis or upon a change of condition as indicated to ensure the resident's/legal representative's choices were honored timely... 3.1-4(d)		committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observations, and interview, the facility failed to ensure kitchen sanitation was maintained for 40 of 41 residents who resided at the facility and ate their meals prepared in the kitchen. Findings included: On 8/10/2023 at 9:06 AM an observation of kitchen with Cook 2 was completed. The steam table had a white residue located on the lids. The steamer had a white residue coming down from the bottom of the door. Behind the steam table, the panel on the wall had multiple brown specks all over. The panel was coming down off the wall, behind the panel could be observed. In front of the coffee machine there were sticky brown substances all over. The oven toaster had build up layers of black flaky particles on top and inside. The oven had discolored particles located on the front. The stove had burnt layers, black substances located all over and food particles inside of the burner. During an interview at that time, Cook 2 indicated she was the only employee in the kitchen on 8/10/23. They had about 40 residents to eat out of the kitchen, and she would prep for everyone. During an observation on 8/10/2023 at 11:44 AM, Cook 2 was taking temperatures of the food. The lids of the steam table were pulled off and placed below the steam table, on the shelve there were	F 0812	**F-812** It is the policy of the facility to ensure the dietary department Stores, prepares, distributes and serves food in accordance with professional standards for food service safety. Including to ensure to ensure the kitchen, dry storage room, and equipment are clean and in good repair and safe food handling is maintained throughout meal service. Residents who reside in the facility have the potential to be affected by this finding. On August 13th, 2023 a complete deep cleaning of the kitchen occurred. The kitchen cleaning logs were audited to ensure cleaning was routine cleaning was taking place. At an in-service held by the on for dietary staff and maintenance the following was reviewed: 1. Kitchen cleaning policy and procedure 2. Environmental repairs policy and procedures – related to chipping paint on walls and	09/01/2023

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	several white residue spots. The lids were placed on that shelf. During lunch service, there was another staff observed putting up the shipment in the dry storage area located in the back of the kitchen. No cleaning was observed. In an interview on 8/10/2023 at 1:32 PM, Cook 2 indicated the kitchens didn't have a cleaning schedule. The DM and her just picked out what they were going to clean and clean it. The dishwasher, and the coffee machine should be cleaned twice a week, the stove was cleaned once a week. The steam table and the steamer were once a day. The steam table was to be cleaned and drained. The panel on the wall started to come off when they moved the steam table along the wall about a week prior. It was sideways but it just got in the way there,sto they moved it along the wall. The panel started to come off due to the steam. They told the maintenance man they needed it replaced but he was no longer here. In an observation at 2:00 PM with the Regional Operation Manager of the kitchen, all areas were observed. During an interview at that time, the Regional Operation Manager indicated the DM was off that day. So, they asked another staff member from a different facility to come and help. The Regional Operation Manager was aware they did not have a schedule for cleaning and indicated they did not have a facility policy. In an interview on 8/15/2023 at 9:52 AM, the Director of Nursing indicated there was one person in the facility that does not eat from the kitchen. The facility census was 41. 3.1-21(i)(1) and (3)		ceilings. 3. Proper documentation of kitchen cleaning logs. At an in-service held by the Regional Director of Operations on August 17th, 2023 for all dietary and maintenance staff the following was reviewed: 1. Kitchen Sanitation/Cleaning policy and procedures 2. Daily/Weekly/Monthly Cleaning Schedules 3. Proper documentation of kitchen cleaning logs. Any staff who fail to comply with the points of the in-services will be further educated and or progressively disciplined as indicated. The Dietary Manager will review all cleaning logs 5 times daily to ensure compliance. This monitoring will continue for a minimum of 6 months until 95% compliance and then will stop. At the monthly QAPI meeting, the monitoring of the Dietary Manager/ Administrator / Designee Cleaning log audits will be reviewed. 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	

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			Plan will be monitored by the Administrator weekly until resolution.	
F 0865 SS=E Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and			

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	§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.			

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	§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to ensure a process was in place to identify and correct quality deficiencies for 41 of 41 residents currently residing in the facility.	F 0865	**F- 865** It is the policy of the facility to ensure a process is in place to identify and correct quality deficiencies for all residents in the building.	09/01/2023

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	Findings include: A QAPI (Quality Assurance Performance Improvement) committee list was provided by the Administrator on 08/14/23 at 10:00 AM. The member list included the Administrator, Director of Nursing, Infection Preventionist, Medical Director, Business Office Manager, Maintenance, Activities, Dietary, Pharmacy, and Medical Records. There was no policy and procedure provided prior to exit regarding QAPI. In an interview on 08/16/23 at 10:51 AM the Administrator indicated the QA committee met monthly. Issues in the facility were tracked and trended through the committee monthly. She indicated the QAPI process was utilized to improve processes within the facility. The facility had a schedule of processes to review each month to ensure improvement of operations. The Administrator indicated the performance improvement plan for Advanced Directives had begun 08/14/23. The facility annual survey completed on 09/29/22 identified noncompliance regarding Advanced Directives. The facility was also found to be noncompliant regarding Advanced Directives on 08/16/23. Refer to tag F0578. 3.1-52		Any resident who resides in the facility has the potential to be affected by this finding An Ad Hoc QAPI meeting was held on 8/14/23 to implement a performance improvement plan regarding advanced directive monitoring in the building. Education was provided by the RDO during the meeting regarding the QAPI policy procedure, and process of implementation of Performance improvement plans. On 9/1/23, at an inservice provided by the RDO, The QAPI Policy and Procedure was reviewed with all department heads. All QAPI plans, and action plans will be monitored by the administrator weekly for a minimum of 6 months. At the monthly QAPI meeting the monitoring of this weekly audit 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.	