PRINTED: 12/09/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE	COMPLETED 10/22/2024			
	PROVIDER OR SUPPLIER S OF PRINCETON,		1	TREET ADDRESS, CITY, STAT 020 W VINE ST PRINCETON, IN 47670	E, ZIP COD	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLA  EFIX (EACH CORRECTIVE A  CROSS-REFERENCED  DEFICE	TO THE APPROPRIATE	(X5) COMPLETION DATE
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN00443 the allegations are of Survey dates: October Provider number: 1002 Census Bed Type: SNF/NF:59 Total:59 Census Payor Type Medicare: 4 Medicaid: 47 Other: 8 Total: 59 These deficiencies accordance with 41	ber 16, 17, 18, 21, & 22, 2024 00175 55275 7440 : :	F 0000	Preparation and/ this plan of corre or this corrective constitute an adr agreement by thi facts alleged or of forth in this state deficiencies. The and specific corre prepared and/or compliance with Laws. Facility's of	action in general, action does not mission of is facility of the conclusions set ment of e plan of correction ective actions are executed in State and Federal date of alleged -22-2024. Facility questing paper	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(i Notify of Changes Based on observation review, the facility consultation was pro- alterations occurred		F 0580	It is the policy o	f this facility to sician is to alterations in	11/22/2024
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE		(X6) DATE

Katherine Seibel HFA 11/15/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HNA811 Facility ID: 000175 If continuation sheet Page 1 of 42

PRINTED: FORM APPROVED OMB NO. 0938-039

12/09/2024 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE crushed medications received. (Resident 47) medications. What corrective actions will be Finding includes: accomplished for those residents found to be affected On 10/18/24 at 10:23 A.M., Resident 47's clinical by the deficient practice: record was reviewed. Resident 47 was admitted on The DON/Designee assessed 6/7/24. Diagnoses included, but were not limited resident 47 on 10-22-2024, and to, dementia, major depressive disorder, and no negative outcome related to anxiety. the cited practice. How other residents having the The most recent Significant change MDS potential to be affected by the (Minimum Data Set) assessment, dated 9/13/24, same deficient practices will indicated Resident 47 was severely cognitively be identified and what impaired, required partial assistance from staff for corrective action will be taken: eating, toileting, and bathing, and was completely The DON/Designee completed an dependent on staff for transfers. audit for residents requiring medications requiring to be A progress note, dated 10/17/24 at 12:32 P.M., crushed prior to administration and indicated Resident 47 had been given her notified the MD and obtained medications in a crushed form. orders to crush medications on 11-13-2024. The clinical record, including physician orders, What measures will be put in progress notes, care plan, and assessments, place and what systemic lacked an order for medications to be crushed changes will be made to prior to administration or physician notification ensure that deficient practice indicating resident need for medications to be does not reoccur: crushed for administration. The DON/Designee in-serviced the nursing staff on obtaining a During a random observation on 10/22/24 at 9:01 physician order for residents

During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing indicated she was unable to

A.M., LPN (Licensed Practical Nurse) 16 placed

medication into a medication cup, crushed the

medications in chocolate pudding. LPN 16 took

the medication and pudding mixture to Resident

47 and spooned the medications into Resident

medications together, and mixed the crushed

four tablets and opened one capsule of

Event ID: HNA811 Facility ID: 000175 Page 2 of 42 If continuation sheet

that require medications to be

member that fails to comply

disciplined as indicated.

for review. Audits will be brought to QAPI monthly for

determine when it is

crushed. Additionally, any staff

with the points of this in-service

will be further educated and/or

Audits will be brought to QAPI

review and the QAPI team will

47's mouth.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		155275	B. WING			10/22/	2024
	PROVIDER OR SUPPLIER		1	020 W	DDRESS, CITY, STATE, ZIP COD VINE ST ETON, IN 47670		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	crushing Resident 4	ler or evaluation related to 7's medications.  11 A.M., the Director of Nursing			appropriate to stop audits.  The DON/Designee will audit random medication observations for residents	10	
	provided a policy tit	_			having medications crushed		
		ted 2/2017, that indicated			verify physician notification	'	
		nt's Medication Administration			and order obtained weekly x	4	
		ad each order entirely. Remove			weeks, then 5 random		
	the medication from	n the drawer. If there is any			medication observations		
		n the MAR and the label,			weekly x 4 weeks, then 3		
		lers before administering			random medication		
		medications only after checking			observations monthly x 4		
		' reference. Refer to medication Iministration when when added			months. If the facility is within		
		., applesauce, juice, milk, etc.".			95% compliance at the end o		
	to any substance i.e.	., applesauce, Juice, milk, etc			months, the monitoring will be stopped. Results of the	)e	
	3.1-5(a)(3)				monitoring will be reviewed a	af	
	3.1 3(u)(3)				the monthly QAPI meeting. A		
					concerns will have been		
					addressed. However, any		
					patterns will be identified. Ar	ıy	
					needed Action Plan will be		
					written by the QAPI committee		
					Any written Action Plan will be		
					monitored by the Administra weekly until resolved.	tor	
					DOC: 11-22-2024		
<b>-</b>							
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)( Comprehensive A	iii) ssessments & Timing					
		riew and interview, the facility	F 0636	;	Tag# 636 MDS /Admission		11/22/2024
		dents' MDS (Minimum Data			assessment.		
		vere completed within 14 days			It is the policy of this facility	to	
		esident reviewed for accidents			ensure residents MDS		
		wed for advanced directives.			Assessments are completed		
	(Resident 259 and F	Resident 261)			within 14 days after admission	on.	
	Findings included:				What corrective actions will I	be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 3 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED
		155275	B. WI	NG		10/22/2024
	PROVIDER OR SUPPLIE		•	1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, IN 47670	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OE CORDECTIONI	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	record was reviewed MDS dated 10/9/24 and was not comple on 10/2/24.  2. On 10/21/24 at 1 clinical record was Admission MDS disprogress and was not comple on 10/22/24 at 9:4 Nursing) indicated Admission MDS beafter admission to the state of the state o	5 A.M., the DON (Director of it was expected that an e completed within 14 days facility, and the facility followed Assessment Instrument)			accomplished for those residents found to be affected by the deficient practice:  The MDS Nurse/Designee submitted the MDS for reside 261 on 10-22-2024 and reside 259 on 10-22-2024.  How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be take The MDS nurse/designee completed a 90 day look bace for new admissions on 11-13-2024 for submission of admission MDS within 14 day of admission.  What measures will be put in place and what systemic changes will be made to ensure that deficient practice The ADM/Designee complete an in-service with the MDS Nurse on completing new admission MDS's within 14 days of admission.  Additionally, any staff member that fails to comply with the points of this in-service will further educated and/or disciplined.  How the corrective actions we be monitored to ensure the deficient practices will not recur: Audit results will be brought to QAPI for review until QAPI deems it no longer than the points of the province o	ent ent the e en: k n ys

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/09/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIE		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The DON/Designee will audit new admissions and re-admissions for submission on admission MDS within 14 days of admission x 6 month If the facility is within 95% compliance at the end of 6 months, the monitoring will stopped. Results of the monitoring will be reviewed the monthly QAPI meeting. A concerns will have been addressed. However, any patterns will be identified. An needed Action Plan will be written by the QAPI committ Any written Action Plan will monitored by the Administrative weekly until resolved.	on ns. be at Any ny ee. be
F 0641	483.20(g)			DOC: 11-22-2024	
SS=D Bldg. 00	interview, the facil (Minimum Data S accurately for 1 of of 2 residents for r	ion, record review, and lity failed to ensure the MDS et) Assessments were completed 2 residents reviewed for falls, 1 nutrition, 1 of 5 residents cessary medications. (Resident	F 0641	Tag# 641 MDS accuracy It is the policy of this facility ensure the MDS Assessmen are accurately coded to chai alarms, weight loss and unnecessary medications What corrective actions will accomplished for those	ts r

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

residents found to be affected by the deficient practice:

Page 5 of 42

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155275	B. W	ING		10/22/2	2024
		<u> </u>		STREET 4	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIE	R			VINE ST		
WATERS	OF PRINCETON,	THE			ETON, IN 47670		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1:44 A.M., Resident 50 was			The MDS Nurse/Designee		
	_	a chair in the activities room			completed submitted a		
		attached to the resident's			modified MDS for Resident		
	clothing.				to accurately code the chair		
	On 10/19/24 / 1.2	5 D.M. Dagidant 50			alarm and significant weigh	ι	
		5 P.M., Resident 50 was			loss on 11-11-2024 and on		
	with a chair alarm.	a chair in the activities room			Resident 30 for accurately		
	with a chair alarm.				coding resident for not receiving an antiplatelet		
	On 10/21/24 at 0.54	5 P.M., Resident 50 was			medication on 10-22-2024.		
		a chair in the activities without	ithout		How other residents having	the	
a chair alarm.				potential to be affected by the			
					same deficient practices wil		
	On 10/18/24 at 9:5	3 A.M., Resident 50's clinical			be identified and what		
		ed. Diagnoses included, but			corrective action will be take	en:	
		, weakness, osteoarthritis, and			The MDS Nurse completed a	-	
	dementia.	, , ,			audit for residents with chair		
					alarms, significant loss and		
	The current Quarte	rly MDS Assessment dated			modified the MDS Assessm		
		Resident 50 was moderately			as needed. The MDS Nurse		
		ed. The resident needed			completed an audit of MDS		
	_	eting, dressing, and mobility.			Assessments that were		
		ot coded for the quarterly			completed for residents cod	led	
	assessment for a ch	air alarm or significant weight			for antiplatelets and verify		
	loss.				resident receiving medication	on	
					on 11-13-2024.		
		order included, but were not			What measures will be put i	n	
ı	limited to:	l , , mi · · · ·			place and what systemic		
	_	lar texture, Thin Liquids			changes will be made to		
	_	ed foods with meals as			ensure that deficient practic	e	
	available dated 2/2	1124.			does not recur.		
	Thorasses	are for about alarma D			The Regional MDS Nurse		
	There were no orde devices.	ers for chair alarms or Dycem			completed an in-service with		
	ucvices.				the MDS nurse on acute cod	_	
	The current fall 1	k care plan lacked interventions			on 11-13-2024. Additionally		
		nd a Dycem device.			any staff member that fails t		
	101 a Chan diaim ai	na a Dycenii utviet.			comply with the points of th in-service will be further	iio	
	The current care also	an lacked a intervention for			educated and/or disciplined	lae	
	fortified foods with				needed.	us	

STATEME	NT OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURV COMPLETED 10/22/2024	EY
	PROVIDER OR SUPPLIER S OF PRINCETON,		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE OPRIATE	(X5) MPLETION DATE
	9/9/2024 at 12:02 P recommendation to adding Dycem or of During an interview MDS (Minimum Di indicated the chair a MDS Assessment.  During an interview DON (Director of N policy of the facility Assessment Instrum Assessment.2. On Resident 30's clinic Diagnoses included dementia and hyper The most recent An Set) assessment, da 30 was cognitively assistance from staff transfers, and was r antianxiety, anticoa hypoglycemic medi lookback period.  Physician orders for 2024 lacked an anti During an interview MDS Coordinator i medication marked the Annual MDS as	access chair for need of ther devices.  y on 10/21/24 at 10:35 A.M., the ata Assessment) Coordinator alarm should have been in the on 10/21/24 at 3:15 P.M., the Nursing) indicated it was the y to use the RAI (Resident ment) as a guide for the MDS 10/17/24 at 12:54 P.M., al record was reviewed. It, but were not limited to, tension.  Inual MDS (Minimum Data ted 10/2/24, indicated Resident intact, required partial off for toileting, bathing, and ecciving antipsychotic, gulant, antiplatelet, and ications during the 7-day  The September 2024 and October platelet medication.  You on 10/22/24 at 8:52 A.M., the indicated the antiplatelet as received by Resident 30 on issessment, dated 10/2/24, was I Resident 30 had not received		How the corrective action be monitored to ensure to deficient practices will not recur:  The DON/Designee will as MDS Assessments for accoding for residents with alarms and significant will loss and verify residents for antiplatelets are received the medication weekly as months. If the facility is will stopped. Results of the monitoring will be review the monthly QAPI meeting concerns will have been addressed. However, any patterns will be identified needed Action Plan will written by the QAPI com Any written Action Plan will written by the Administration weekly until resolved.  DOC: 11-22-2024	the oot  udit ccurate cchair eight coded iving 6 within nd of 6 will be wed at ng. Any d. Any oe mittee. will be	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HNA811 Facility ID: 000175 If continuation sheet Page 7 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155275	B. WING 10/2		10/22/	2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	L			VINE ST		
WATERS	S OF PRINCETON,	THE		PRINCETON, IN 47670			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0656	483.21(b)(1)(3)						
SS=D	Develop/Implemer	nt Comprehensive Care Plan					
Bldg. 00							
		and record review, the facility	F 06	556	Tag # F656 Care plan		11/22/2024
	_	re plans for 1 of 1 residents			development		
		unication. A care plan was not			It is the policy of this facility to		
	_	ents with English as a second			develop a communication care		
	language. (Resident	: 50)			plan for residents with English	as	
					a second language.		
	Findings include:				1) What corrective action(s) w		
	4 0 40/45/04				accomplished for those reside		
		0:01 A.M., during a random			found to have been affected b	y the	
		dent 50's room there was no			deficient practice;		
		ation board available in room to			The DON/Designee updated		
	meet the resident's r	needs if asked.			Resident 50's communication	care	
	0 10/10/04 : 0.50				plan on 11-14-2024. The		
		3 A.M., Resident 50's clinical			DON/Designee created a		
		d. Diagnoses included, but			communication board for Resi	dent	
		weakness, osteoarthritis, and			50 on 11-14-2024.		
	dementia.				2) How other resident's having	-	
	The	de MDC Assessment dated			potential to be affected by the		
		ly MDS Assessment dated			same practice will be identified		
		Resident 50 was moderately d. The resident needed			and what corrective action(s)	WIII	
		eting, dressing, and mobility.			be taken; The DON/Designee completed	d on	
	_	ot coded this assessment for a			audit for residents that use	J all	
	chair alarm or signi				English as a second language	\ on	
	Chair alarm of signi	neant weight loss.			11-14-2024, a care plan and		
	The clinical record	lacked an order for the use of			communication board were		
	communication dev				implemented as needed.		
	communication dev	ices.			3) what measures will be put i	nto	
	The clinical record	lacked a care plan to			place or what systematic char		
		dent's communication needs.			will be made to ensure that the	-	
					deficient practice does not rec		
	On 10/21/24 at 10:0	04 A.M., the communication			Upon	,	
		under a stack of papers on			The DON/Designee in-service	<sub>:</sub> d	
		er and readily available.			staff on developing a		
		,			communication care plan and	use	
	On 10/21/24 at 2:22	P.M., the resident was			of a communication board for		
		wheelchair in the activities			residents that use English as	а	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER		1020	T ADDRESS, CITY, STATE, ZIP COD W VINE ST CETON, IN 47670	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		with a CNA (Certified Nurse he CNA indicated that she		second language on 11-14-20	
		d the resident and made no		Additionally, any staff that fail	S IO
		ate with the resident because		comply with the points of this in-service will be further educ	ata d
	she was preoccupie				
	she was preoccupie	d passing ice water.		and/or disciplined as indicated	
	During an intervious	on 10/21/24 at 10:15 A.M., the		<ol> <li>how corrective action(s) w monitored to ensure the defic</li> </ol>	
		Director of Nursing) indicated			
		re plan for communication		practice will not recur: Audits	
		•		be brought to QAPI for review The DON/Designee will audit	
	since the resident spoke Spanish as a first			9	
	language.			plans and communication boards	
	On 10/22/24 at 12:5	66 P.M., the DON (Director of	for current residents, new admissions and re-admissions 5		o 5
	Nursing) provided a current, non-date policy			times a week x 4 weeks, then	
	"Communication in the Predominant Language."			times a week x 4 weeks , then	
		d" the resident has the right to			'
		eand communication with		once a week x 4 weeks, then once a month x 3 months. If the	ho.
		as and with services with the			
	_	it has the right to be full		facility is within 95% complian	ice
		age that he or she understand		at the end of 6 months, the	
	of his/her health sta			monitoring will be stopped.	ho
	of ms/ner nearm sta	tus		Results of the monitoring will reviewed at the monthly QAP	
	On 10/21/24 at 3:15	P.M., the DON provided a		meeting. Any concerns will ha	
	current policy "Base	eline Care Plan Assessment/		been addressed. However, ar	
		re Plan" revised 3/23/21. The		patterns will be identified. Any	-
	policy indicated"t	he comprehensive care plan		needed Action Plan will be wr	
	will further expand	on the resident's medical,		by the QAPI committee. Any	
	nursing, physical fu	nctioning needs. These		written Action Plan will be	
	needs will be based	on observation, record		monitored by the Administrate	or
	review, interviews,	and thorough		weekly until resolved.	
	assessmentsthe co	emprehensive care plan shall			
	include any speciali	zed services"			
				5) DOC 11-22-2024	
	3.1-35(b)(1)				
	3.1-35(d)(2)(A)				
F 0657	483.21(b)(2)(i)-(iii)				
SS=D	Care Plan Timing				
Bldg. 00		and toviolon			
2.29.00	Based on record rev	riew and interview the facility,	F 0657	Tag # F657 Care Plan Timii	ng 11/22/2024

12/09/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure that documentation of and Revision interventions were not revised for 1 of 2 residents It is the policy of this facility to reviewed for falls and revise a residents care plan ensure care plans are updated after they returned to facility from a hospital with a new fall intervention after a admission with a urinary tract infection and sepsis fall and when a resident returns for 1 of 1 resident reviewed for urinary tract from the hospital with a new infections. (Resident 36, Resident 50). diagnosis. 1) What corrective action(s) will be Findings include: accomplished for those resident's found to have been affected by the 1. On 10/18/24 at 9:53 A.M., Resident 50's clinical deficient practice; record was reviewed. Diagnoses included, but The DON/Designee reviewed and were not limited to, weakness, osteoarthritis, and updated resident 50's fall care dementia. plan and at risk for weight loss care plan on 10-24-2024 and The current Quarterly MDS (Minimum Data Set) resident 36's care plan for urinary Assessment dated 9/24/24, indicated Resident 50 tract infection and sepsis on was moderately cognitively impaired. The resident 10-25-2024. needed supervision for toileting, dressing, and 2) How other resident's having the mobility. The resident was not coded in potential to be affected by the assessment for a chair alarm or significant weight same practice will be identified and what corrective action(s) will be taken: There were no orders for chair alarms or Dycem All residents of the facility have devices. the potential to be affected by the cited practice, therefore, this plan The current fall risk care plan lacked interventions of correction applies to all for a chair alarm and a Dycem device. residents that reside in the facility. 3) what measures will be put into During an interview on 10/21/24 at 10:12 A.M., the place or what systematic changes ADON (Assistant Director of Nursing) indicated will be made to ensure that the care plans need to be updated with each fall and deficient practice does not recur; there should be an intervention for the Dycem and Upon

FORM CMS-2567(02-99) Previous Versions Obsolete

(ESRD).

chair alarms.2. On 10/21/24 at 11:54 A.M., Resident

36's clinical record was reviewed. The diagnoses

The most recent Quarterly MDS Assessment, on

intact, had complex medical conditions included,

10/4/24, indicated Resident 36 was cognitively

included Sepsis and End Stage Renal Disease

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

The DON/Designee in-serviced the

MDS Nurse and nursing staff on

revising and updating care plans

from the hospital on 11-15-2024.

Additionally, any staff that fails to comply with the points of this

after a resident falls or returns

Page 10 of 42

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMP		(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIER		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	disease.  Resident 36's clinic care plan to reflect to sepsis with a Urinar On 10/22/24 at 9:45 Nursing) indicated to should have been upon 10/21/24 at 3:15 current policy "Base Comprehensive Carpolicy indicated"t will be reviewed an minimum. The facilicare plans more offeresident's conditions health/psychological 3.1-35(a)	5 A.M., the DON (Director of chat a resident's care plan odated after a hospitalization.  5 P.M., the DON provided a cline Care Plan Assessment/ re Plan" revised 3/23/21. The comprehensive care plan d updated every quarter at a city may need to be review the con based on changes in the s and/or newly developed		in-service will be further educe and/or disciplined as indicated 4) how corrective action(s) we monitored to ensure the defice practice will not recur: Audits be brought to QAPI for review. The DON/Designee will audite plans after falls for updated interventions and re-admission with new diagnosis 5 times at week x 4 weeks, then 3 times week x 4 weeks, then once at week x 4 weeks, then once at week x 4 weeks, then once at month x 3 months. If the facilie within 95% compliance at the of 6 months, the monitoring westopped. Results of the monite will be reviewed at the month QAPI meeting. Any concerns have been addressed. However any patterns will be identified needed Action Plan will be wroby the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	d. ill be ient will /. care  ns  a  ty is end ill be oring y will /er, Any itten
F 0658 SS=D Bldg. 00	Standards Based on interview failed to ensure prace met professional staresident diagnosed	and record review, the facility etitioner's diagnostic practices andard of care for 1 of 1 with scizoaffective disorder after admission. (Resident 47)	F 0658	Tag # F658 Services Provide Meet Professional Standards It is the policy of this facility to ensure practitioners diagnosti practices meet professional standards.  1) What corrective action(s) we see the professional standards.	c

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 11 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accomplished for those resident's On 10/18/24 at 10:23 A.M., Resident 47's clinical found to have been affected by the record was reviewed. Resident 47 was admitted on deficient practice; 6/7/24. Diagnoses included, but were not limited The DON/Designee notified the to, dementia, major depressive disorder, and practitioner on 11-11-2024 and anxiety. clarified and removed diagnosis of schizoaffective disorder. The most recent Significant change MDS 2) How other resident's having the (Minimum Data Set) assessment, dated 9/13/24, potential to be affected by the indicated Resident 47 was severely cognitively same practice will be identified impaired, required partial assistance from staff for and what corrective action(s) will eating, toileting, and bathing, was completely be taken: dependent on staff for transfers, and received The DON/Designee completed an antipsychotic, antianxiety, and antidepressant audit of residents receiving medications during the 7-day lookback period. antipsychotic medications to verify diagnosis added after admissions Current physician orders included, but were not have a physician evaluation related to the new diagnosis on Depakote sprinkles (antiepileptic medication) oral 11-20-2024. capsule delayed release 125 MG, Give one capsule The DON/Designee completed and by mouth three times a day, Start date 6/8/24 audit for residents receiving psychoactive medications for risperidone (atypical antipsychotic medication) orders to monitor side effects and oral tablet 1 MG, Give one tablet by mouth two care plan related to behaviors on times a day for, Start date 6/8/2024 11-14-2024. 3) what measures will be put into Alprazolam (antianxiety medication) tablet 0.5 MG, place or what systematic changes Give one tablet by mouth two times a day, Start will be made to ensure that the date 6/13/2024 deficient practice does not recur; Upon Escitalopram oxalate (antidepressant medication) The DON/Designee in-serviced the oral tablet 10 MG, Give one tablet by mouth one physician on completing an time a day, Start date 6/8/2024 evaluation when adding a new psych diagnosis on 11-21-2024. Hydroxyzine HCl (antihistamine medication) 25 The DON/Designee educated MG, Give one tablet every eight hours as needed, nursing staff to implement order to Start date 6/12/24 monitor side effects of

FORM CMS-2567(02-99) Previous Versions Obsolete

The clinical record lacked a care plan related to

behavioral disturbances requiring antipsychotic

Event ID:

**HNA811** 

Facility ID: 000175

If continuation sheet

psychoactive medications and to

monitor every shift on 11-19-2024.

Additionally, any staff that fails to

Page 12 of 42

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR medication use or n	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION conitoring for side effects of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  comply with the points of this	DATE
	indicated Resident amg twice a day for aphysician selected to associated with the behaviors to schizos.  A pharmacy medical indicated Resident amg three times a das selected to change to the medication from bipolar disorder.  During an interview Director of Nursing find a physician evaluation aphysician evaluation from the physician evaluation of the physician eva	ation review, dated 7/13/24, 47 was receiving risperdone 1 dementia with behaviors. The o change the diagnosis medication from dementia with		in-service will be further educe and/or disciplined as indicated 4) how corrective action(s) we monitored to ensure the deficipractice will not recur: Audits be brought to QAPI for review The DON/Designee will audit pharmacy recommendations monthly for evaluations when adding new psych diagnoses months. The DON/Designee waudit 10 random resident recepsychoactive medications for effect monitoring and care plaweekly x 4 weeks, then 5 rand residents weekly x 6 random residents monthly x months. If the facility is within 95% compliance at the end of months, the monitoring will be stopped. Results of the monitivial be reviewed at the monthl QAPI meeting. Any concerns have been addressed. However, any patterns will be identified. needed Action Plan will be wroby the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	d. ill be ient will c.  x 6 will eiving side in dom hen 4 6 6 e oring y will eer, Any itten
F 0686 SS=D Bldg. 00	Ulcer	Prevent/Heal Pressure	F 0686	Tag# F686 Treatment/Servic	res 11/22/2024
		ure care consistent with		to Prevent/Heal Pressure Uld	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 13 of 42

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155275	
NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON. HOTO WOUNDS (X5)  PREFIX (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:	
NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  1020 W VINE ST PRINCETON, IN 47670  (X5) PREFIX FRANCOF CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  IT IS the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  1020 W VINE ST PRINCETON, IN 47670  (X5) PREFIX FRANCOF CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  IT IS the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	—
WATERS OF PRINCETON, THE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  PRINCETON, IN 47670  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  PREFIX TAG  PREFIX TAG PROVIDERS PLAN OF CORRECTION TAG TAG  PREFIX TAG PROVIDERS TAG	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  PREFIX TAG  COMPLETION DATE  COMPLETION DATE  COMPLETION DATE	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  PREFIX TAG  It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  TAG  DEFICIENCY)  DATE  It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	1
to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  pressure ulcers from progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  progressing by administering the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
personnel for 1 of 2 residents reviewed for wounds. (Resident 16)  Finding includes:  the treatment as ordered.  What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	
wounds. (Resident 16)  What corrective actions will be accomplished for those Finding includes:  Finding includes:  Finding includes:  Tesidents found to be affected by the deficient practice:	
Finding includes:  accomplished for those residents found to be affected by the deficient practice:	
Finding includes:  residents found to be affected by the deficient practice:	
by the deficient practice:	
On 10/17/24 at 12:00 D.M. Desident 16's clinical	
record was reviewed. Diagnoses included, but  Resident 16 no negative	
were not limited to, chronic obstructive pulmonary  outcome by the alleged	
disease and diabetes mellitus. deficient practice on	
10-24-2024.	
The most recent Quarterly MDS (Minimum Data  How other residents having the	
Set) assessment, dated 8/19/24, indicated Resident potential to be affected by the	
16 was cognitively intact, required partial same deficient practices will	
assistance from staff for toileting and bathing, and  be identified and what	
was completely dependent on staff for transfers.  corrective action will be taken:	
DON/Designee completed an	
Current physician orders included, but were not  limited to:  audit for residents with  pressure ulcer to treatment	
Sacral wound: Cleanse and pat dry, apply skin  prep, and cover with bordered gauze every day  orders and interventions  ordered in place on 11-20-2024.	
shift, Start date 10/12/24.  Any concerns were immediately addressed.	
Left heel: cleanse with wound cleanser, apply skin  What measures will be put in	
prep to peri wound, apply collagen to wound bed,  place and what systemic	
and cover with silver alginate. Secure with  changes will be made to	
abdominal pad and rolled gauze every day shift,  abdominal pad and rolled gauze every day shift,  ensure that deficient practice	
Start date 9/14/24. does not recur.	
DON/Designee in-serviced	
Use wedge or pillow to alleviate pressure off of nursing staff on completing	
wound to sacrum- document any non-compliance treatments as ordered and	
every shift, Start date 9/6/24 interventions in place as	
ordered and in-serviced QMA's	
Off loading device to left foot every shift when in on Scope of Practice that	
bed, Start date 9/11/23 includes not completing	
treatment as ordered on	
Apply skin prep to left heel every shift for prevent 11-19-2024. Additionally, any	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155275	B. WI	ING		10/22/2024
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>		1020 W	VINE ST	
WATERS	OF PRINCETON,	THE		PRINCETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG		DATE
	skin break down, St	art date 8/16/24			staff that fails to comply with	
	Coro plan:				the points of this in-service v	WIII
	Care plan:	n sacral region- Pressure ulcer			be further educated and/or disciplined as indicated.	
	_	/25/24. Interventions: air			How the corrective actions w	dill distribution
	_	7/24; treatment as ordered,			be monitored to ensure the	/III
	4/25/24.	1, 2, irodinoni do ordorod,			deficient practices will not	
					recur:	
	Wound is present or	n left heel- Pressure ulcer			The DON/Designee will audit	
	•	/15/23. Interventions: air			completion of treatment orde	
mattress on bed, 9/17/24; treatment as ordered,				by nurse and interventions in		
2/7/24.				place as ordered on 10 rando		
				residents weekly x 4 weeks,		
	(Stage three pressur	re ulcer is defined as a			then 5 random residents	
	full-thickness tissue	loss that extends through the			weekly x 4 weeks, then 3	
	skin into deeper tiss	sue and fat.)			random residents monthly x	4
					months. If the facility is 95%	
		dated 8/29/24 through			compliance at the end of 6	
	10/17/24 indicated t	the following weekly			months, then monitoring car	1
	measurements:				be stopped. Results of the	
	Stage three left heel				monitoring will be reviewed a	
	10/17: 2.6 cm x 3 cm				the monthly QAPI meeting. A	Any
	10/10: 2.5 cm x 3.1				concerns will have been	
	10/3: 2.6 cm x 3.2 c				addressed. However, any	
	9/26: 2.6 cm x 3.2 c				patterns will be identified. Ar	ny
	9/19: 3.1 cm x 4.1 c				needed Action Plan will be	
	9/12: 1.6 cm x 1.2 c 9/5: 1.4 cm x 1 cm x				written by QAPI committee.	ha
	8/29: 1 cm x 0.5 x 0				Any written Action Plan will I monitored by the Administra	
	0/29. 1 CIII X U.3 X U	,. 1 CIII			weekly until resolved.	ioi
	Stage three sacral w	yound:			woonly until 1630lveu.	
	10/17: 4.4 cm x 7.1					
	10/10: 4.5 cm x 8.2				DOC: 11-22-2024	
	10/3: 0.2 cm x 0.2 c					
	9/26: 0.8 cm x 1.4 c					
	9/19: 2 cm x 1.5 cm					
	9/12: 1.9 cm x 1.2 c					
	9/6: 2.5 cm x 2 cm					
	8/29: 2 cm x 2 cm x	0.1 cm				
	I		1			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMPLETED 10/22/2024	
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	D	
				VINE ST ETON, IN 47670		
	OF PRINCETON,			- 1 ON, IIN 47070	T	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	ON
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCIT	DATE	
	_	ates treatment administration  y a QMA on the electronic				
		stration record during the last				
	60 day period:	stration record during the last				
	Stage three left hee	l wound:				
	9/12/24	1				
	9/20/24					
	9/23/24					
	9/27/24					
	10/2/24					
	10/3/24					
	10/17/24					
	10/21/24					
	Stage three sacral wound:					
	9/12/24					
	9/13/24					
	9/20/24					
	9/27/24					
	10/2/24					
	10/3/24					
	10/17/24					
	10/21/24					
		ates treatment administration				
		d as completed during the last				
	60 days:					
	Stage three left hee	l wound:				
	9/1/24					
	9/13/24					
	10/13/24					
	10/16/24					
	10/18/24					
	Stage three sacral w	vound:				
	10/11/24					
	10/16/24					
		, including electronic				
	administration reco	rd and progress notes, did not				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

Page 16 of 42

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED
		155275	B. WING		10/22/2024
	ROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD VINE ST ETON, IN 47670	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	indicate any refusal the last 60 days.	of wound treatment during			
	A laboratory wound	l culture, resulted on 9/16/24,			
		6's stage three pressure ulcer			
	left heel wound was positive for the organism				
	methicillin resistant staphylococcus aureus.				
	10/10/24, indicated reduction air flow m 10/3/24, due to long Unfortunately, the a developed issues, so on a regular mattres size worsened in siz During an interview Assistant Director o (Qualified Medicati administer treatmen	of pressure mattress of (resident) was placed back as. At today's visit the wound are and shape.  You on 10/22/24 at 11:11 A.M., the of Nursing indicated a QMA on Aide) should never tts.			
	provided a documer Aide Scope of Pract shall not document any medication that person or not admin tasks shall not be in practice: Administer	A.M., the Director of Nursing and titled "Qualified Medication tice" that indicated "The QMA in a resident's clinical record was administered by another distered at all. The following cluded in the QMA scope of a treatment that involves			
	three, and four decu				
		3 A.M., a policy related to ng of wounds was requested ed.			
	3.1-40(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HNA811 Facility ID: 000175 If continuation sheet Page 17 of 42

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/22/2024		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydratio  Based on record refailed to ensure die followed in 1 of 3 r (Resident 34)  Findings include:  On 10/17/24 at 1:1 record was reviewed were not limited to disease, schizoaffed.  The current Quarter Assessment dated 9 was moderated cogneeded partial assis dressing. The resid weight loss during.	n Status Maintenance view and interview, the facility t recommendations were residents reviewed for nutrition.  1 P.M., Resident 34's clinical ad. Diagnoses included, but gastro-esophageal reflux ctive disorder, and dementia.  rly MDS (Minimum Data Set) 0/19/24 indicated Resident 50 mitively impaired. The resident stance to for toileting and ent was noted for significant the assessment period.  cluded, but were not limited, ar texture, and thin liquid 1/12/24.  ords as follows: 1. 124.5 Lbs. (Pounds) 1. 126.5 Lbs. 1. 128.0 Lbs. 1. 128.0 Lbs. 1. 124.5 Lbs.	F 0692	Tag# F692 Nutrition/Hydratic Status Maintenance It is the policy of the facility ensure that dietary recommendations are being followed. What corrective actions will accomplished for those residents found to be affected by the deficient practice: Resident 34 diet order was updated on 11/13/24 to reflect the dietary recommendations. The DON/Designee assessed Resident 34 no negative outcome by the alleged deficient practice. How other residents having to potential to be affected by the same deficient practices will be identified and what corrective action will be take DON/Designee completed as day look back audit to ensur all dietary recommendations are being followed through with on 11/19/2024. What measures will be put in place and what systemic changes will be made to	to 11/22/2024  to 11/22/2024  to the eeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeee		
	7/29/2024 10:12 A.P. 7/29/2024 3:08 P.N. 7/22/2024 12:20 P. 7/15/2024 10:20 A 7/8/2024 9:37 A.M. 7/3/2024 11:07 A.M.	M. 130.0 Lbs. M. 128.5 Lbs. M. 129.5 Lbs 130.0 Lbs.		ensure that deficient practice does not recur.  DON/Designee in-serviced nursing and dietary staff on following dietary	e		

FORM CMS-2567(02-99) Previous Versions Obsolete

7/1/2024 11:19 A.M.

Event ID:

130.0 Lbs.

HNA811

Facility ID: 000175

If continuation sheet

recommendations on 11/19/24.

Page 18 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG	00	COMPLI	ETED
		155275	B. WING			10/22/	2024
		<u> </u>	STR	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VINE ST		
WATERS	OF PRINCETON,	THE			TON, IN 47670		
	· I			-	,	ı	OV.5
(X4) ID		STATEMENT OF DEFICIENCIE	ID	.	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAC	j			DATE
	6/26/2024 1:14 P.M				Additionally, any staff that fa		
	6/10/2024 9:08 A.M				to comply with the points of		
	6/5/2024 10:25 A.M				this in-service will be further		
	5/27/2024 10:31 A.				educated and/or disciplined	as	
	5/20/2024 1:18 P.M				indicated.		
	5/13/2024 10:02 A.				Have the same attress and		
	5/6/2024 10:00 A.M				How the corrective actions w	/111	
	5/1/2024 2:09 P.M.				be monitored to ensure the		
	4/29/2024 1:20 P.M 4/22/2024 12:31 P.I				deficient practices will not		
	4/17/2024 12:31 P.I				recur:		
	4/1//2024 10:33 A.	IVI. 140.3 LOS.			The DON/Designee will audit		
					dietary recommendations		
	The weight loss calculator indicated the resident had a 15.1% weight loss in 6 months				weekly x 6 months. If the facility is 95% compliance at		
	liad a 13.176 weight	l loss in o months			the end of 6 months, then		
	A Mutrition at Rick	Review (NAR) dated 5/8/24, at			monitoring can be stopped.		
		ended fortified food with					
		event further weight loss.			Results of the monitoring will be reviewed at the monthly	"	
	breaklast to help pro	event further weight loss.			QAPI meeting. Any concerns		
	A NAR dated 5/22/	24, at 3:24 P.M., recommended			will have been addressed.	'	
		meals to help prevent further			However, any patterns will be	_	
	weight loss.	nears to help prevent farther			identified. Any needed Action		
	weight less.				Plan will be written by QAPI		
	A NAR dated 5/29/	24, at 3:15 P.M., recommended			committee. Any written Action	on	
		meals to help discourage			Plan will be monitored by the		
	further weight loss.				Administrator weekly until		
					resolved.		
	A NAR dated 6/12/2	24, at 2:41 P.M., recommended					
		meals to help discourage any					
	further weight loss.				DOC: 11-22-2024		
	-						
	A NAR dated 6/21/2	24, at 4:15 P.M., recommended					
	fortified food with r	meals to help discourage any					
	further weight loss	the diet indicated it was					
		n fluids, fortified foods with					
	meals. The record la	acked an order for change of of					
	diet.						
		7/24, at 9:43 A.M., indicated the					
	resident had a weigl	ht warning when the resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 19 of 42

PRINTED: 12/09/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPL	(X3) DATE SURVEY  COMPLETED  10/22/2024	
	PROVIDER OR SUPPLIE		1020 W	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
IAG	was at 126.5 pound months of 15.01 pound ite was general, record lacked an or meals.  The current care please the resident is at risurded items and derivative offer substitutions than) 50 % (Percention During an interview DON (Director of should be on supplementally weight loss.  During an interview Diet Manager indicated items about the suggesting using for change had not been declared in the suggestion of the suggestion had not been declared in the suggestion had not been declared in the suggestion h	ds, had a weight change in 6 bunds over 6 months, and the egular, with thin liquids. The order for fortified foods with  an for nutritional risk indicates sk related to BMI (Body Mass nan) 25, with a diagnosis of mentia. Interventions included, d to, serve diet as ordered and if resident consumes < (less nt) of meal dated 9/15/23.  W on 10/18/24 at 9:13 A.M., the Nursing) indicated the resident ements if there is significant  W on 10/18/24 at 9:17 A.M., the cated he had talked with the resident's weight loss and were ortified shakes, boost, etc. and	IAG			DATE
	3.1-46(2)	e resident nutruonai status				
F 0756	483.45(c)(1)(2)(4	)(5)				

FORM CMS-2567(02-99) Previous Versions Obsolete

SS=D

483.45(c)(1)(2)(4)(5)

Drug Regimen Review, Report Irregular, Act

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

Page 20 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155275	B. WI	NG		10/22/	2024
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.					VINE ST		
WATERS	OF PRINCETON,	IHE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	15	DATE
Bldg. 00	On						
Ŭ	Based on record rev	iew and interview, the facility	F 07	756	Tag# F 756		11/22/2024
		armacy recommendation was			It is the intent of this facility	to	11/22/2021
	_	residents reviewed for			ensure pharmacy		
	unnecessary medica				recommendations are follow	ed	
	,	.,			and care plans are in place for		
	Finding includes:				each medication.		
					What corrective actions will I	he	
	On 10/18/24 at 10:23 A.M., Resident 47's clinical				accomplished for those		
		d. Resident 47 was admitted on			residents found to be affecte	d	
		ncluded, but were not limited			by the deficient practice:	_	
	_	gnitive communication deficit.			Resident 47 was assessed w	ith	
	,	<del></del>			no negative effects were		
	The most recent Significant Change MDS (Minimum Data Set) assessment, dated 9/13/24,				identified and Omeprazole w	as	
					discontinued and care plan		
		7 was severely cognitively			updated on 11-8-2024.		
		partial assistance from staff for			How other residents having t	he	
		l bathing, and was completely			potential to be affected by th		
	dependent on staff f				same deficient practices will		
	1				be identified and what		
	Physician orders inc	eluded, but were not limited to:			corrective action will be take	n:	
		pump inhibitor (PPI)			DON/Designee completed a 9		
		capsule delayed release, give			day look back of pharmacy		
	· ·	th one time a day. Start date			recommendations and verific	ed	
	6/8/24	,			care plans in place and		
					physician notified of any		
	The clinical record l	acked a care plan related to the			concerns on 11-20-2024.		
		p inhibitor (PPI) medication.					
		• •			What measures will be put in	1	
	A pharmacy recomr	nendation, dated 9/14/24,			place and what systemic		
	indicated a pharmac	y recommendation to reduce			changes will be made to		
	or hold Resident 47'	s omeprazole medication for			ensure that deficient practice	.	
		GI symptoms occur,			does not recur.		
	discontinue the med				DON/Designee in-serviced st	aff	
					on following through on the		
	The eMAR (electron	nic medication administration			pharmacy recommendations		
	•	neprazole 40 MG was held for			and care plans in place on		
	· ·	again. The clinical record,			11/19/24. Additionally, any st	aff	
	•	re plans, assessments, and			that fails to comply with the		
	-	ed documentation if any GI			points of this in-service will I	<sub>oe</sub>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 21 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	1	COMPLETED	
		155275	B. WI	ING		10/22/	2024	
	PROVIDER OR SUPPLIER		•	1020 W	ADDRESS, CITY, STATE, ZIP COD I VINE ST ETON, IN 47670			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		during the 14 day hold period			further educated and/or			
		esident 47 continuing the			disciplined as indicated.			
	provided an undate Recommendations' the facility to moni regimen review con if indicated. The ob- residents are receiv effective and safe. ' contact the DON ar concern will be add	8 A.M., the Director of Nursing d policy titled "Pharmacy" the stated "It is the policy of tor medication by pharmacy inducted monthly or more often objective being to ensure that the ing medications that are. The pharmacy consultant will and or the physician and the diressed and resolved per rection. This will be			How the corrective actions we be monitored to ensure the deficient practices will not recur:  The DON/Designee will audit pharmacy recommendations for completion and care plan monthly x 6 months. If the facility is 95% compliance at the end of 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	is is is e n		
					DOC: 11-22-2024			
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medicatio	n Error Rts 5 Prcnt or More						
	review, the facility were administered and professional state observed during me Resident 39, Resident	on, interview, and record failed to ensure medications according to physician's orders andard for 4 of 4 residents edication pass. (Resident 10, ent 42, Resident 30) Five were observed during 31 ror in medication	F 07	759	Tag# F759 Free of Medication Error Rates 5 Percent or Mo It is the policy of this facility ensure it is free of medication error rate of less than 5%. What corrective actions will accomplished for those residents found to be affected	re to n be	11/22/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 22 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE administration. This resulted in a 16.13 error rate. by the deficient practice: Resident 10, 39, 42, 30 was Findings include: assessed by DON on 10/20/24 and no negative effects related to alleged deficient practice. 1. During a medication administration on 10/18/24 at 8:02 A.M., RN 6 prepared the following How other residents having the medications for Resident 10: potential to be affected by the one tablet of certirizine 10 mg, one tablet of same deficient practices will desvenlafaxine 100 mg, one tablet of famotidine 10 be identified and what mg, one tablet of furosemide 40 mg, one tablet of corrective action will be taken: meloxicam 7.5 mg, one tablet of Nuedexta 20-10mg, All residents have the potential one tablet of vitamin D3 5000 units, one tablet of to be affected by the alleged asenapine 5mg, and mixed a packet of cited practice, therefore, this polyethylene glycol in 8oz of water. RN 6 took the plan of correction applies to all medications to Resident 10; Resident 10 took all of residents that reside in the the medications orally and drank the polyethylene facility. gylcol mixed in water. What measures will be put in RN 6 then went to the EDK and removed a tablet place and what systemic of metoprolol 25mg, placed the pill in a medication changes will be made to cup, and gave the medication to Resident 10. ensure that deficient practice does not recur. On 10/18/24 at 9:45 A.M., Resident 10's clinical The DON/Designee in-serviced record was reviewed. Physician orders included, the nursing staff and QMA's on but were not limited to: asenapine 5mg take **Medication Administration** medication sublingually. policy on 11/19/24. Additionally, any staff that fails to comply During the medication administration, asenapine with the points of this in-service 5mg was not given to Resident 10 sublingually. will be further educated and/or disciplined as indicated. 2. During the medication administration on 10/18/24 at 8:22 A.M., RN 6 prepared the following How the corrective actions will medications for Resident 39: be monitored to ensure the one tablet of metformin 500mg, one soft gel of deficient practices will not docusate sodium 100mg, one tablet of recur: escitalopram 10 mg, one tablet of Farxiga 5 mg, DON/Designee will complete 10 one tablet of levetiracetam 1000mg, one tablet of random medication metoprolol 25 mg, two tablets of quetiapine 25mg, observations weekly x 4 weeks, attached a needle to the Admelog insulin pen and then 5 random medication turned the dial to 10 units. RN 6 entered Resident observation x 4weeks. If the

39's room and handed Resident 39 the cup of

facility is within 95% compliant

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f i			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE	
		155275	B. W	ING		10/22/2	2024
WATERS	PROVIDER OR SUPPLIER	THE		1020 W PRINCE	ADDRESS, CITY, STATE, ZIP COD VINE ST ETON, IN 47670		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		dministered 10 units of			after 6 months, the monitoring		
	Admelog insulin in Resident 39's right lower abdomen.				will be stopped. Results of the monitoring will be reviewed a		
					the monthly QAPI meeting. A		
	During the medicat	ion administration, RN 6 did			concerns will have been	y	
	not prime the insulin pen needle prior to administration.  Resident 39's clinical record was reviewed on 10/18/24 at 10:00 A.M.  3. During the medication administration on 10/18/24 at 8:40 A.M., RN 7 prepared the following				addressed. However, any		
					patterns will be identified. Ar	ıv	
					needed Action Plan will be		
					written by the QAPI committe	e.	
					Any written Action Plan will I		
					monitored by the Administra	tor	
					weekly until resolved.		
	insulin for Resident 42: Lantus insulin pen 70 units and lispro insulin pen						
	•	ned each insulin pen with two			DOC: 44 22 2024		
	_	n, then set the dial to 70 units			DOC: 11-22-2024		
	_	en and 50 units to insulin					
	_	en administered 70 units of					
		e resident's left lower abdomen					
		lispro in the resident's left					
	upper abdomen.						
	_	ion administration, RN 7 did n pen needle properly prior to					
	Resident 42's clinic 10/18/24 at 2:27 P.I	al record was reviewed on M.					
	4. During the medic	cation administration on					
	I -	M., RN 7 prepared the following					
	medications for Res						
	one tablet of Eliquis	s 5 mg, two tablets of Tylenol					
	235 mg, one tablet	of folic acid 1mg, one tablet of					
	lansoprazole 15mg,	one tablet of vitamin D3 5000					
	units, one tablet of	levothyroxine 50mcg, one					
	tablet of lisinopril 2	20 mg, one tablet of loratadine					
	10 mg, a multivitan	nin tablet, and one tablet of					
	olanzapine 5 mg. R	N 7 took the cup of medications					
	to Resident 30 and	Resident 30 took the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 24 of 42

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	COMPLETION
	record was reviewed included, but were regive 2.5mg by mour 10/1/24.  During an interviewed	6 A.M., Resident 30's clinical d. Current physician orders not limited to: olanzapine 2.5mg th one time a day, Start date			
	medication card for instructions on the c a day. RN 7 indicate available and Resid incorrect dose during	edication cart and pulled the olanzapine and confirmed the card indicated give 5mg twice ed there were not 2.5 mg tablets ent 30 had been given the g the medication pass.			
	provided a policy ti Administration", da "Review the resider Record (MAR). Rea the medication from discrepancy betwee	of A.M., the Director of Nursing titled "Medication ted 2/2017, that indicated at's Medication Administration ad each order entirely. Remove a the drawer. If there is any in the MAR and the label, there before administering			
	provided an insulin that stated "Always each injection. Performance that you get an accupen and needle work bubbles. A. Select a dosage selector. B. and keep it to removinjection. Take off the discard it. C. Hold the pointing upwards. It that any air bubbles	of A.M., the Director of Nursing injection instruction leaflet perform the safety test before perming the safety test ensures that dose by: ensuring that k properly, removing air dose of 2 units by turning the Take off the outer needle cap we the used needle after the inner needle cap and the pen with the needle D. Tap the insulin reservoir so rise up towards the needle. E. button all the way in. Check if			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 25 of 42

CENTERS FOR ME	DICARE & MEDICA	AID SERVICES			OMB NO. 0938-039	
STATEMENT OI AND PLAN OF C	F DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/22/2024	
	TIDER OR SUPPLIER		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST EETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
pe is 3. F 0761 48		f the needle. You may have to est several times before insulin and Biologicals				
Baire www mm to mm  Fi  1. the fo Hi or La ex ca La Hi re in idi tw in op lal	view, the facility of the properly dated edications refriger destroy expired medication carts observed and edication cart and edication edication date edication date edication date, pen predefined edication edication edication edication tag edication tag edication tag edication tag edication edi	and, interview and record failed to ensure medications and labeled, failed to keep rated until opening, and failed nedications for 2 of 2 served. (100 hall west 200 hall east medication cart)  ation on 10/16/24 at 9:03 A.M., dication cart contained the in - opened; lacked opened on or needle attached and not opened; lacked opened on or needle attached and not ps- expiration date 10/13/24 expiration date 9/23/24 in- lacked identification tag or irration date 10/14/24 in lame rubbed off of ens - seal is unopened, tag on erate until opening" o-Stat (liquid protein)- lacked attion on 10/16/24 at 9:25	F 0761	Tag# F761 Label/Store Drug and Biologicals It is the policy of this facility ensure insulins and Pro-Star are labeled with open and discard dates, discard expiremedications and medication are refrigerated as indicated What corrective actions will accomplished for those residents found to be affected by the deficient practice:  No residents were identified the alleged cited practice.  The DON/designee immediately removed the undated insulins, expired medications and medication were re-ordered 11-23-2024. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken the DON/Designee audited medications and expired medications on 11/15/24. Medications were re-ordered as needed.	or to t  ed is i. be ed I for  the he I	

FORM CMS-2567(02-99) Previous Versions Obsolete

A.M., the 100 hall west medication cart contained

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

What measures will be put in

Page 26 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155275	B. W	NG		10/22/	2024
NAME OF I	PROVIDER OR SUPPLIER	₹		l	ADDRESS, CITY, STATE, ZIP COD		
					/ VINE ST		
WATERS	S OF PRINCETON,	THE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	the following items				place and what systemic		
	_	en- expiration date 9/11/24			changes will be made to		
	insulin lispro pen-	-			ensure that deficient practice	<b>.</b>	
		n- opened; lacked opened on			does not recur.	•	
	or expiration date	in opened, mened opened on			The DON/Designee in-service	he	
	_	ı pens - opened; lacked			nursing staff on dating insuli		
	opened on or expira				and disposing of insulin by t		
		opened; lacked opened on or			discard date, placing	116	
	expiration date	opened, lacked opened on of			medications in the refrigerate	or.	
	_	in nanc seal is unananad tag			and ensuring all medication		
	Two novolog insulin pens - seal is unopened, tag on insulin states "refrigerate until opening"				labeled properly on 11/19/24.		
	Ozempic (antidiabetic medication) injection-						
	unopened, tag on injection box states "refrigerate				Additionally, any staff that fa	IIS	
					to comply with the points of	1	
	until opening" two Basaglar insulin pens - opened; lacked				this in-service will be further		
					educated and/or disciplined	as	
	opened on or expira				indicated.		
	_	ro-Stat (liquid protein)- lacked					
	label or opened date	e			How the corrective actions w	/111	
	D	10/00/04 + 11 46 4 35 - 1			be monitored to ensure the		
	_	v on 10/22/24 at 11:46 A.M., the			deficient practices will not		
	_	stated the facility was aware			recur:		
		the medication carts not being			DON/Designee will complete		
		y due to pharmacy delivering			an audit of insulin pens, vials	3,	
	the injections withou	out ice packs.			and bottles for expiration		
	0 10/01/04 (2.2)	IDM I D' ( CM '			dates, properly labeled and		
		P.M., the Director of Nursing			refrigerate as indicated 5 tim		
		tled "Medication Storage in			a week x 4 weeks, then 3 time		
	the Facility", dated				a week x 4weeks, then once		
		iologicals are stored safety,			week x 4 months. If the facility	-	
		rly following the manufacture			is within 95% compliant after		
		endations. Medications			months, the monitoring will b	oe	
		tion" or temperature between			stopped. Results of the the		
	_	eit and 46 degrees Fahrenheit			monitoring will be reviewed a		
		erator. Outdated, contaminated,			the monthly QAPI meeting. A	ny	
		gs and those in containers,			concerns will have been		
		soiled, or without secure			addressed. However, any		
	closures will be immediately withdrawn from				patterns will be identified. Ar	ıy	
	stock. They will be disposed of according to drug				needed Action Plan will be		
		s, and reordered from the			written by the QAPI committe		
	pharmacy if a curre	ent order exists."			Any written Action Plan will I	oe	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 27 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPLI	
		155275	B. W	ING		10/22/2	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	3.1-25(j) 3.1-25(m) 3.1-25(o)				monitored by the Administrative weekly until resolved.  DOC: 11-22-2024	ator	
F 0804 SS=E Bldg. 00	Temp Based on observation review, the facility is	pear, Palatable/Prefer on, interview, and record failed to ensure that food was	F 08	804	Tag# F804 Nutritive Value/Appear, Palatable/Pre	fer	11/22/2024
	served at palatable to tested for temperature. Finding includes:  On 10/16/24 at 10:1 the food was cold.  On 10/16/24 at 10:3 the food was cold.  On 10/16/24 at 12:1 the food tasted bad at the food tasted b	remperatures for 1 of 1 trays are. (200-hall)  3 A.M., Resident 52 indicated  4 P.M., Resident 31 indicated  4 P.M., Resident 15 indicated and was cold.  5 A.M., Resident 42 indicated and was cold.  2 P.M., a test tray was peratures for that meal were:  F (Fahrenheit)  9.7 F  9 F			Temp It is the intent of this facility ensure food temperature are within range and served at the appropriate temperatures. What corrective actions will accomplished for those residents found to be affected by the deficient practice: Residents 52, 31, 15, 42 were assessed and not negatively affected related to the allege deficient practice on 10-23-2024. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be take All residents who reside in the facility have the potential to affected by the cited practice therefore, this plan of correction applies to all residents that reside in the	to he be ed the ne he he he he he	
	indicated he was aw and hoped to get ne	about 148 F when served. He vare cold food was an issue w insulated holders and carts			facility.  What measures will be put in	,	
	to help.				place and what systemic		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

Page 28 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIE S OF PRINCETON,		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	On 10/22/24 at 10:0 provided an undate policy that indicate	05 A.M., the Dietary Manager d current Food Temperatures d "Best efforts will be made to ot and cold foods cold at		changes will be made to ensure that deficient practic does not recur.  The Dietary Manager/Design in-serviced dietary staff on monitoring food temperature on 11/19/24. Additionally, an staff member that fails to comply with the points of thi in-service will be further educated and/or disciplined indicated.  How the corrective actions who be monitored to ensure the deficient practices will not recur:  The Dietary Manager/Design will monitor food temperature for proper temperature daily for a random meal service services 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a month x months. If the facility is 95% compliance at the end of 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed the monthly QAPI meeting. A concerns will have been addressed. However, any patterns will be identified. An needed Action Plan will be written by QAPI committee. Any written Action Plan will monitored by the Administra weekly until resolved.	e ee e
Ī	1		ı		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 29 of 42

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155275 B. WING 10/22/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE DOC: 11-22-2024 F 0805 483.60(d)(3) SS=E Food in Form to Meet Individual Needs Bldg. 00 Based on observation, interview, and record F 0805 Tag# F804 Nutritive 11/22/2024 review, the facility failed to ensure food was Value/Appear, Palatable/Prefer correctly prepared for 4 of 4 residents who Temp received puree altered diets. It is the intent of this facility to ensure food temperature are Finding includes: within range and served at the appropriate temperatures. On 10/17/24 at 10:01 A.M., Cook 5 was observed What corrective actions will be preparing 4 servings of pureed beef and cheddar accomplished for those sandwiches. Cook 5 added the following residents found to be affected ingredients to the blender and blended in between by the deficient practice: each item: Residents 52, 31, 15, 42 were 8 slices of pre-cooked roast beef assessed and not negatively 1-ounce (oz) scoop of mayonnaise affected related to the alleged 1-oz scoop of mayonnaise deficient practice on 1-oz scoop of mayonnaise 10-23-2024. 4 hamburger buns torn up How other residents having the 2 1-oz scoops of mayonnaise potential to be affected by the 2 1-oz scoops of mayonnaise same deficient practices will 4 slices of cheese torn up be identified and what 2 1-oz scoops of mayonnaise corrective action will be taken: All residents who reside in the At that time, Cook 5 indicated the food did not facility have the potential to be look right and it would probably taste like straight affected by the cited practice, mayonnaise. She indicated she usually would add therefore, this plan of broth to help with the consistency, but the recipe correction applies to all did not call for it. That was a new recipe and she residents that reside in the had never made it before. facility. Cook 5 added 4 more 1-oz scoops of mayonnaise. (Total mayonnaise added was 13-oz.) What measures will be put in Cook 5 went to the reach-in refrigerator and place and what systemic

FORM CMS-2567(02-99) Previous Versions Obsolete

obtained milk. The best by date on the milk was

10/16/24. She added a quarter cup of milk to the

blender and blended to pudding consistency.

Event ID:

HNA811

Facility ID: 000175

does not recur.

changes will be made to

ensure that deficient practice

If continuation sheet

Page 30 of 42

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Dietary Manager/Designee On 10/21/24 at 9:37 A.M., the Dietary Manager in-serviced dietary staff on provided the recipe for the Beef and Cheddar monitoring food temperature Sandwich that was prepared by Cook 5 on on 11/19/24. Additionally, any 10/17/24. staff member that fails to The ingredients for one serving included: comply with the points of this 2-oz shaved roast beef in-service will be further 1 slice cheese educated and/or disciplined as 1 bun indicated. The puree preparation instructions indicated to How the corrective actions will place in food processor and process to a smooth be monitored to ensure the pudding like consistency. Add mayo, a little at a deficient practices will not time, as needed to achieve smooth consistency. recur: No serving size was identified per serving. The Dietary Manager/Designee will monitor food temperatures On 10/21/24 at 2:32 P.M., the Dietary Manager for proper temperature daily indicated the menu and recipes were new to the for a random meal service facility. He indicated 13 oz of mayonnaise was a services 5 times a week x 4 lot of mayonnaise and he would have advised weeks, then 3 times a week x 4 Cook 5 to use milk to help achieve the appropriate weeks, then once a week for 4 consistency. At that time, he indicated expired weeks, then once a month x 3 food was thrown out daily and he didn't realize the months. If the facility is 95% milk in the refrigerator was expired. compliance at the end of 6 months, then monitoring can On 10/22/24 at 11:00 A.M., the Dietary Manager be stopped. Results of the provided an undated current Characteristics and monitoring will be reviewed at Procedures for Consistency Modified Foods the monthly QAPI meeting. Any policy that indicated "Properly prepared pureed concerns will have been food has the following characteristics...it is soft addressed. However, any (pudding like consistency) ... Successfully patterns will be identified. Any pureeing food depends on using the right process needed Action Plan will be as well as the right equipment. If you cannot written by QAPI committee. puree an item to meet the above characteristics Any written Action Plan will be with the processing equipment that you have, monitored by the Administrator contact your manager or dietician to determine an weekly until resolved. appropriate substitute".

FORM CMS-2567(02-99) Previous Versions Obsolete

On 10/22/24 at 11:00 A.M., the Dietary Manager

provided a current Pureed Food Preparation

Event ID:

HNA811

Facility ID: 000175

DOC: 11-22-2024

If continuation sheet

Page 31 of 42

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE policy, dated 10/25/23, that indicated "Milk, broth, soup, gravy, juice, and margarine will be used to thin the pureed food ... The flavor of pureed foods will be checked as these items must have the same flavor as original regular menu item". On 10/22/24 at 11:21 A.M., the Director of Nursing (DON) provided a current First In First Out (FIFO) policy, dated 4/2017, that indicated "Stock must be used before the expiration date. Items not used by the expiration date will be discarded". 3.1-21(a)(3) F 0812 483.60(i)(1)(2) SS=E Food Bldg. 00 Procurement, Store/Prepare/Serve-Sanitary Based on observation, interview, and record F 0812 Tag# F812 Food Procurement, 11/22/2024 review, the facility failed to ensure food was Store/Prepare/Serve-Sanitary prepared under sanitary conditions during 3 of 3 It is the intent of this facility to kitchen observations and 1 of 1 dining ensure food is prepared under observations. Staff did not wear hairnets, and sanitary conditions with gloves were not changed before touching food hairnets and gloves to be worn items. (Dietary Manager, Cook 5, Cook 14, properly. Activities Department Staff) What corrective actions will be accomplished for those Findings include: residents found to be affected by the deficient practice: 1. During a lunchtime dining observation on Residents were assessed and 10/16/24 at 12:00 P.M., Activities Department staff not negatively affected related were observed assembling and serving hot dogs to alleged deficient practice on 10-23-2024, by the for lunch in the dining room. Residents placed orders and staff assembled buns, hot dogs, DON/Designee. condiments, and chili in the dining room. Staff did How other residents having the not change gloves in between touching the hot potential to be affected by the dog buns and touching condiment bottles. Staff same deficient practices will were not wearing hairnets while assembling food. be identified and what

FORM CMS-2567(02-99) Previous Versions Obsolete

2. On 10/16/24 at 9:12 A.M., the Dietary Manager

was observed in the kitchen without a beard net.

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

corrective action will be taken:

All residents who reside in the

facility have the potential to be

Page 32 of 42

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/22/2024		
	NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PECULATORY OF LSC INEVITIEVING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION	
PREFIX TAG	REGULATORY OF Cook 5 and Cook 1 wearing a hairnet th hair.  3. On 10/17/24 at 1 was observed in the Cook 5 was observed hairnet that did not  4. On 10/21/24 at 1 observed taking ten the steam table. Cook touched her face, the plate heater, the owe pad. Without chang a bread bag and retrand prepared a chic observed wearing a of her hair. At that the observed in the kitce on 10/21/24 at 2:32 indicated hairnets we All hair should be concluding facial hair gloves should be chitems and before to	A LSC IDENTIFYING INFORMATION  4 were observed in the kitchen and did not cover all of their  0:01 A.M., the Dietary Manager whitchen without a beard net. and in the kitchen wearing a cover all of her hair.  1:30 A.M., Cook 5 was apperatures of lunch foods on ook 5 was wearing gloves. She are refrigerator, a cart, the hot en, a cooking tray, and a hot ging gloves, Cook 5 reached in rieved a bun, opened the bun, ken sandwich. Cook 5 was hairnet that did not cover all time, the Dietary Manager was then without a beard net.  2 P.M., the Dietary Manager were worn when handling food. Sovered while wearing a hairnet or At that time, he indicated sanged after touching nonfood suching food, and Cook 5		TAG TAG	affected by this alleged deficient practice, therefore, this plan of correction applie to all residents that reside in the facility.  What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.  The Dietary Manager/Designin-serviced dietary and activistaff on the proper use of hairnets and gloves on 11/15/24. Additionally, any stath fails to comply with the points of this in-service will further educated and/or disciplined.  How the corrective actions we be monitored to ensure the deficient practices will not recur: The Dietary Manager/Designin will complete validation of	s ee ity aff	DATE	
	bun.  On 10/22/24 at 10:0 provided an undate indicated "Gloved I contact surface that soiled. If used, sing only one task (such food or with raw an purpose, and discar or when interruptio	of gloves before touching the  OS A.M., the Dietary Manager of Glove Use policy that nands are considered a food can get contaminated or le use gloves shall be used for as working with ready-to-eat himal food), used for no other ded when damaged or soiled on occur in the operation hands. They get soiled.			hairnet and glove usage on 6 random staff members week x 4 weeks, then 3 random staff members weekly x 4 weeks, then 2 random staff member monthly x 3 months. If the facility is within 95% compliance at the end of 6 months, then monitoring car be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. A concerns will have been	ly aff		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 33 of 42

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 10/22/2024						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0040	gloves must be char washed: During finecessaryto preve changing tasks".  On 10/22/24 at 10:0 provided an undated Restraints/Jewelry/lindicated "Hairnet, worn at all times in  On 10/22/24 at 12:5 provided a current I Hygiene policy, dat restraints will be we be well-trimmed an hair restraint".  3.1-21(i)(2) 3.1-21(i)(3)	Nail Polish policy that hat or hair restraint will be the kitchen".  6 P.M., the Administrator Employee Health and Personal ed 9/17/23, that indicated "Hair orn at all times. Beards should d covered with an appropriate		addressed. However, any patterns will be identified. An needed Action Plan will be written by the QAPI committ Any written Action Plan will monitored by the Administrative weekly until resolved.  DOC: 11-22-2024	ee. be			
F 0842 SS=E Bldg. 00	Based on interview failed to ensure doc accurate for 4 of 5 r of 5 reviewed for la residents reviewed documentation and documented by the service, medication when administered (Resident 53, Resid 16, Resident 259, R Findings include:	- Identifiable Information  and record review, the facility umentation was complete and esidents reviewed for insulin, 5 te medications and 1 of 2 for wound care. Insulin wound treatments were not staff that provided the s were documented correctly one hour and 45 minutes late. ent 15, Resident 42, Resident esident 17, Resident 22)	F 0842	Tag# 842 Resident Records Identifiable Informtion It is the policy of this facility the Medication Administration Records to accurately reflect the administration of insulin and wound treat to be documented by the nurse administering.  What corrective actions will accomplished for those residents found to be affected by the deficient practice: The DON/Designee assessed Resident 53, 16, 15, 42, 259,	for on t			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 34 of 42

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE record was reviewed. Diagnoses included, but 22 on 10/22/24 and no negative were not limited to, type 2 diabetes mellitus. outcome related to the cited The most current Admission Minimum Data Set How other residents having the (MDS) Assessment, dated 8/20/24, indicated potential to be affected by the Resident 53 was cognitively intact and received same deficient practices will insulin. be identified and what corrective action will be taken: Physician orders included, but were not limited to: All residents who receive Insulin lispro (a fast-acting insulin) 100 insulin and wound treatments units/milliliter (mL) - Inject as per sliding scale: if have the potential to be 150 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = impacted by this deficient 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; practice, therefore, this plan of 401+=7units subcutaneously before meals for correction applies to all diabetes mellitus, dated 8/14/24 residents that reside in the facility. The Medication Administration Record (MAR) from 8/7/24 to 10/17/24 indicated Qualified What measures will be put in Medication Aide (QMA) 10 administered insulin place and what systemic lispro to Resident 53 on the following dates: changes will be made to 8/24/24 at 7:02 A.M. ensure that deficient practice 8/24/24 at 5:24 P.M. does not recur. 9/7/24 at 12:48 P.M. DON/Designee will in-service 9/9/24 at 5:28 P.M. nursing staff on the policy 9/24/24 at 10:20 A.M. "Medication Administration", 9/30/24 at 10:04 A.M. signing off medications and treatments timely and for Medication Administration progress notes from nurses to sign off medications QMA 10 indicated the insulin was given by the that the QMA is unable to nurse on duty on those days. The progress notes administer by 11/20/24. did not specify which nurse on duty gave the Additionally, any staff member insulin. that fails to comply with the points of this in-service will be The clinical record lacked documentation from the further educated and/or nurse that administered the insulin on those disciplined as indicated. days.2. On 10/17/24 at 12:08 P.M., Resident 16's clinical record was reviewed. Resident 16 was How the corrective actions will admitted on 2/13/19. Diagnoses included, but were be monitored to ensure the

FORM CMS-2567(02-99) Previous Versions Obsolete

not limited to, chronic obstructive pulmonary

disease and diabetes mellitus.

Event ID:

HNA811

Facility ID: 000175

recur:

deficient practices will not

If continuation sheet

Page 35 of 42

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155275 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE DON/Designee will audit insulin The most recent Quarterly MDS (Minimum Data and wound treatment Set) assessment, dated 8/19/24, indicated Resident administration for 10 random residents a week x 4 weeks for 16 was cognitively intact, required partial assistance from staff for toileting and bathing, and documentation in the EMR. was completely dependent on staff for transfers. then 5 random residents a week for 4 weeks, then 3 Current physician orders included, but were not random residents a monthly x 2 limited to: months. ="" span="">Results of Basaglar (insulin medication) Inject 10 unit the monitoring will be subcutaneously every morning and at bedtime for reviewed at the monthly QAPI diabetes, Start date 4/9/24 meeting. Any concerns will have been addressed. On the following dates subcutaneous insulin However, any patterns will be administration was documented by QMA 10 on identified. Any needed Action the electronic medication administration record Plan will be written by the during the last 30 day period: QAPI committee. Any written 9/20/24 8:00 A.M. Action Plan will be monitored 9/27/24 8:00 A.M. by the Administrator weekly 10/2/24 8:00 A.M. until resolved. 10/3/24 8:00 A.M. 10/16/24 8:00 A.M. 10/17/24 8:00 A.M. 10/21/24 8:00 A.M. DOC: 11-22-2024 On 10/22/24 at 9:58 A.M., the Director of Nursing provided a document titled "Qualified Medication Aide Scope of Practice" that indicated "The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all. The following tasks shall not be included in the QMA scope of practice: Administering medication by the injection route, including the following: Subcutaneous route."3. On 10/17/24 at 2:03 P.M., Resident 15's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set)

FORM CMS-2567(02-99) Previous Versions Obsolete

Assessment, on 10/27/24, indicated that the resident was cognitively intact, had diagnoses that included but was not limited to diabetes

Event ID:

HNA811

Facility ID: 000175

Page 36 of 42 If continuation sheet

ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED			
155275			B. WING		10/22/2024			
	PROVIDER OR SUPPLIER		1020 V	STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	``	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE			
1710	mellitus, and receiv		1710		DATE			
	Current orders inclu	ıded:						
	Humalog KwikPen 11/2/23.	(short-acting insulin) dated						
	Resident 15's MAR	(Medication Administration						
		r 2024 indicated that the						
	-	Humalog (insulin) for the						
		nistered by QMA (Qualified						
	Medication Aide) 1							
	10/2/24 8 A.M. and 10/3/24 8 A.M. and							
	10/3/24 8 A.M. and 10/16/24 8 A.M. an							
	10/17/24 8 A.M. an							
	10/1//210111111	- 1 <b>-</b> 1						
	QMA 10 was not qu	ualified to administer insulin.						
	On 10/18/24 at 11:3	30 A.M., Resident 15's MAR						
		istration Record) was						
	reviewed. Resident'	s electronic MAR indicated						
		ceived their medications due						
	at 8 P.M. on 10/15/2	24						
	4 On 10/19/24 at 2	27 D.M. Dogidant 4015 alimical						
		27 P.M., Resident 42's clinical d. The most recent State						
		red 8/9/24, indicated the						
		ively intact and had diagnoses						
		as not limited to diabetes						
	mellitus and receive	ed insulin.						
	Current orders included:  Insulin Lispro Injection Solution 50 units before meals, dated 6/28/24.							
	,							
		tion Solution, inject as per						
	sliding scale before 6/28/24.	meals and bedtime, dated						
ı	L D/ /.8/ /.4.		1	1	I			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 37 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
	155275			ING		10/22/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD VINE ST		
WATERS	WATERS OF PRINCETON, THE				ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Resident 42's MAR (Medication Administration Record) for October 2024 indicated that the following doses of Insulin Lispro injections for the resident were administered by QMA (Qualified Medication Aide) 10:  10/3/24 11 A.M. insulin Lispro 50 units 10/3/24 11 A.M. insulin Lispro sliding scale  QMA 10 was not qualified to administer insulin.  Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24.  5. On 10/16/24 at 3:50 P.M., Resident 259's clinical record was reviewed. The resident was recently admitted and did not have a completed MDS. Resident 259 had diagnoses that included but was not limited to zoster (shingles). Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24.						
	6. On 10/18/24 at 2:30 P.M, Resident 17's clinical record was reviewed. The most recent Quarterly MDS dated 9/16/24, indicated the resident was cognitively intact, had diagnoses that included but was not limited to cerebrovascular accident, and was receiving opioid medications. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24.						
	7. On 10/18/24 at 2:20 P.M., Resident 22's clinical record was reviewed. The most recent Quarterly MDS dated 7/16/24, indicated the resident was cognitively intact, had diagnoses that included but was not limited to coronary artery disease,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811 Facility ID: 000175

If continuation sheet Page 38 of 42

PRINTED: 12/09/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>00</u>			COMPLETED	
155275			B. W	ING		10/22	/2024	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	· ·		1020 W	VINE ST			
WATERS	WATERS OF PRINCETON, THE			PRINCE	ETON, IN 47670			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1	an opioid medication.						
		ic MAR indicated that they						
		eir medications due at 8 P.M.						
	on 10/15/24.							
	On 10/18/24 at 2:40	0 P.M., RN (Registered Nurse) 7						
		id not stay over her scheduled						
		ent 15, Resident 17, Resident 42,						
	~	Resident 22's medications and						
		I to relieve her had called in,						
		night shift gave Residents' 8						
		ate but had not charted they						
	were given.	3						
	Ü							
	On 10/21/24 at 9:40	0 A.M., the Administrator						
	indicated that RN 7	gave some of the scheduled						
		N 22 gave the rest, also that RN						
	22 fixed their docu	mentation to reflect that they						
	had given these me	dications.						
		00 A.M., controlled drug						
	receipt/record/dispo	osition forms were reviewed for						
	Residents 15, 17, 4	2, 259, and 22. These indicated						
		eceived their medications						
		5/24 at 8:00 P.M., at 8:00 P.M.						
	on 10/15/24 with th	ne signature of RN 22.						
	DON (Director of )	Nursing) indicated on 10/21/24,						
	· ·	22 clocked in for their shift on						
	10/15/24 at about 9							
	An official time sta	mp from RN 22's time card on						
		they clocked in for their shift at						
	9:45 P.M.							
	Om 10/21/24 -+ 2 24	DM the Director - f.N						
		OP.M., the Director of Nursing					1	
		at QMAs did not give insulin.						
	A nurse would give	the insulin for the QMA and					1	

FORM CMS-2567(02-99) Previous Versions Obsolete

the QMA could mark it done for the nurse who gave the insulin. At that time, the DON indicated

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

Page 39 of 42

AND PLAN OF CORRECTION IDENTIFI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
F 0880 SS=D Bldg. 00	that one staff could sign off on giving.  On 10/21/24 at 3:12 current Guidelines adated 5/17/23, that you record If you not do it. If you did should you need to time do it properly first documenting wone, then detailing occurred. Never be fake that you are with 3.1-50(a)(1) 3.1-50(a)(2)  483.80(a)(1)(2)(4) Infection Prevention Prevention measure orders for enhanced residents observed in the record was reviewed were not limited to,  The most recent Questions of the second was severely cognitive.	on & Control  on, record review, and ty failed to implement infection s by following physician I barrier precautions for 1 of 1 for wound care. (Resident 6)  40 A.M., Resident 6's clinical d. Diagnoses included, but seizures and bipolar disorder.  harterly MDS (Minimum Data ted 8/16/24, indicated Resident nitively impaired and required om staff for eating, bathing,	F 0880	Tag# F880 Infection Preventiand Control It is the policy of this facility ensure that enhanced barrier precautions are followed. What corrective actions will be accomplished for those residents found to be affecte by the deficient practice: Resident 6 was assessed and not negatively affected relate to alleged deficient practice be the DON/Designee on 10-24-2024. How other residents having the potential to be affected by the same deficient practices will	to De d d d oby		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA811

Facility ID: 000175

If continuation sheet

Page 40 of 42

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155275	B. WING 10/22/2024				
			1	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				VINE ST		
WATERS OF PRINCETON, THE					ETON, IN 47670		
WATERC	OF TRINGLION,	1112		1 Kilvol			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE	
					be identified and what		
		rders included, but were not			corrective action will be take		
	limited to:				All residents who reside in the		
	Ennanced Barrier P	recautions, start date 9/16/24			facility have the potential to	De	
	Laft colf obresion: (	Cleanse with wound cleanser,			affected by this alleged deficient practice, therefore,		
		secure with rolled gauze due			this plan of correction applie		
		ape on skin every day shift,			to all residents that reside in		
	Start date 9/28/24.	ape on skin every day sinit,			the facility.		
	Start date 9/20/21.				the lacinty.		
	During an observati	ion of wound care on 10/21/24			What measures will be put ir	ı	
		(Licensed Practical Nurse)12			place and what systemic		
	· ·	s room. Resident 6's door had a			changes will be made to		
	sign that indicated e	enhanced barrier precautions.			ensure that deficient practice	e	
	LPN 12 washed her	hands, put gloves on, and			does not recur.		
	began opening wou	nd care supplies on a bedside			The DON/Designee in-service	ed	
	table. LPN 12 spray	ved wound cleanser on gauze			the nursing staff on 11/19/24	ı	
	and cleaned Resider	nt 6's wound bed on her left			related to facility policy and		
		d collagen to the wound,			protocol on enhanced barrie	r	
		e around the left lower			precautions. Additionally, ar	ny	
		the gauze with tape, removed			staff that fails to comply with		
	1 -	d a marker to write the date on			will		
		athered the wound supplies,	be further educated/disciplined			ned	
		y, and washed her hands. LPN			as indicated.		
		own while providing wound					
	care.				How the corrective actions w	VIII	
	Dumin a. a.: :	s on 10/22/24 at 9.52 A M 41-			be monitored to ensure the		
		on 10/22/24 at 8:52 A.M., the ndicated Resident 6 had			deficient practices will not		
	wounds that require				recur:		
	precautions.	a chilaneca vallici			DON/Designee will complete validation of enhanced barrie		
	precautions.				precautions are in place on		
	On 10/21/24 at 3:31	P.M., the Director of Nursing			random staff member weekly		
		tled "Enhanced Barrier			4weeks, then 5 random staff		
		12/19/22, that indicated			members weekly x 4 weeks,		
		recautions (EBP) are defined as			then 3 random staff member	s	
		vns and gloves) during			weekly x 4 weeks then 3	-	
		nt care activities that generate			random staff members mont	hly	
	1 -	ansfer of MDROs (multi-drug			x 3 months will be completed	-	
		) in the form of blood or body			on. If the facility is within 95°		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	ì ′	ILDING	nstruction 00	(X3) DATE COMPL 10/22/	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of MRDO or a colonized MRDO."  3.1-18(b)				compliance at the end of 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. A concerns will have been addressed. However, any patterns will be identified. An needed Action Plan will be written by the QAPI committed Any written Action Plan will I monitored by the Administrative weekly until resolved.	at Any ny ee. be	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HNA811 Facility ID: 000175 If continuation sheet Page 42 of 42