STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	11/14/2023

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WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00418816 and IN00418683. Complaint IN00418816- Federal/State deficiencies related to the allegation are cited at F684 and F755. Complaint IN00418683- No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: November 13 and 14, 2023. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 12 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 16, 2023.	F 0000	Deficiency ID: F _ 0000 Completion Date: November 14, 2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is November 30, 2023. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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

Jalena Ball | Administrator | 11/29/2023

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

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to complete wound treatments as ordered by the physician for 1 of 5 residents reviewed for quality of care. (Residents D) Findings include: 1. The clinical record for Resident D was reviewed on 11/13/23 at 11:00 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/31/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hip and knee replacement, hypertension, renal insufficiency, diabetes, anxiety, and depression. a. A physician's order, dated 09/01/23 through 09/27/23, indicated the staff were to cleanse the resident's right third toe with wound cleanser, apply bacitracin (an antibiotic ointment), and cover with a Band-Aid every day shift. The September 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident's right third toe treatment was not completed on 09/15/23, 09/16/23, 09/24/23, 09/26/23, and 09/27/23. b. A physician's order, dated 09/08/23 through 10/02/23, indicated the staff were to cleanse the left lower abdomen with wound cleanser, apply bacitracin, and cover with a bordered gauze dressing every day shift.	F 0684	**F-684 Quality of Care** It is the policy of the facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. Resident D no longer resides at the facility. Residents who reside in the facility have the potential to be affected by this finding. An audit of the TAR related to treatment orders was completed on 11/30/2023. Any changes or corrections were addressed and changed as indicated. DON/Designee will audit the TAR related to treatment orders for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks, then weekly for 1 resident ongoing for a period of no less than 4 months. If facility is within 95 % compliance at the end of 6 months; then monitoring can be stopped.	11/30/2023

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	The September 2023 EMAR/ETAR indicated the resident's left lower abdomen treatment was not completed on 09/15/23, 09/16/23, 09/24/23, and 09/26/23, c. A physician's order, dated 08/26/23 through 10/02/23, indicated the staff were to apply a Mepilex (foam absorbent) dressing to the open area on the left shin every three days on day shift. The September 2023 EMAR/ETAR indicated the resident's left shin treatment was not completed on 09/13/23 and 09/16/23. d. A physician's order, dated 08/26/23 through 10/02/23, indicated the staff were to apply a Mepilex dressing to the open area on the top of the right foot every three days on day shift. The September 2023 EMAR/ETAR indicated the resident's top of the right foot treatment was not completed on 09/13/23 and 09/16/23. e. A physician's order, dated 08/28/23 through 10/04/23, indicated the staff were to apply Balsam Peru-Castor Oil External Ointment to the bilateral buttocks and gluteal cleft every shift. The September 2023 EMAR/ETAR indicated the resident's bilateral buttocks and gluteal cleft treatments were not completed on night shift 09/14/23, on day shift 09/15/23, on day shift 09/16/23, on night shift 09/20/23, and on day shift 09/24/23, and f. A physician's order, dated 09/05/23 through 10/04/23, indicated the staff were to apply Miconazole Nitrate Powder (antifungal powder) to the gluteal cleft, groin, peri-area, abdominal folds,		At an in-service held by the Administrator/Designee on 11/30/23 for all nursing staff the following was reviewed: 1. Following Tx Orders 2. Following Physician Orders 3. MAR/TAR documentation Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **DOC: 11-30-2023**	

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	and under the bilateral breasts twice a day. The September 2023 EMAR/ETAR indicated the resident's gluteal cleft, groin, peri-area, abdominal folds, and under the bilateral breasts treatments were not completed on night shift 09/14/23, on day shift 09/15/23, on day shift 09/16/23, on night shift 09/20/23, and on day shift 09/24/23. During an interview on 11/14/23 at 9:18 A.M., Agency LPN (Licensed Practical Nurse) 5 indicated when administering treatments she would mark that it was completed or input a number indicating the reason why it wasn't completed on the EMAR/ETAR and document in a progress note why it was not administered. If there was a blank in the EMAR/ETAR then it might indicate the treatment was not completed. There shouldn't be any blanks in the EMAR/ETAR. There should always be an explanation as to why something wasn't completed. The current, undated, facility policy titled, "PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS)" was provided by the Administrator on 11/14/23 at 10:39 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." This tag relates to Complaint IN00418816. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

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	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on record review and interview, the facility failed to ensure hospice medications were administered as ordered by the physician for 1 of 4 residents reviewed for medication administration. (Resident M) Findings include: The clinical record for Resident M was reviewed on 11/14/23 at 10:15 A.M. The resident's	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records** It is the policy of this facility to provide routine and emergency drugs and biological to its residents or to obtain them from the contracted pharmacy. Resident M no longer resides at	11/30/2023

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	diagnoses included, but were not limited to, secondary malignant neoplasm of retroperitoneum and peritoneum, dehydration, weakness, and malignant neoplasm of hypopharynx. A Progress Note, dated 11/08/23 at 8:35 P.M., indicated the hospice nurse came to the facility with morphine (a pain medication) and Ativan (an antianxiety medication) for the resident. New orders were received. The hospice nurse indicated the resident was in the end stages of life. The November 2023 EMAR/ETAR indicated the resident had the following physician orders with no documentation the medications were administered on the following dates and times: - A physician's order, with a start date of 11/09/23 at midnight, indicated the resident was to receive Lorazepam (an antianxiety medication) 0.25 ml (milliliters) every 4 hours for hospice. The medication was not administered on 11/09/23 at midnight and 4:00 A.M., - A physician's order, with a start date of 11/09/23 at midnight, indicated the resident was to receive Morphine Sulfate (a liquid pain medication) 0.5 ml every 4 hours for hospice. The medication was not administered on 11/09/23 at midnight and 4:00 A.M. During an interview on 11/14/23 at 9:18 A.M., Agency LPN (Licensed Practical Nurse) 5 indicated when administering medications she would mark that it was completed or input a number indicating the reason why it wasn't completed on the EMAR/ETAR and document in a progress note why it was not administered. If there was a blank in the EMAR/ETAR then it might indicate the medication was not given.		the facility. All Residents on hospice and receiving a controlled substance have the potential to be affected by this deficient practice. An audit was completed by the DON/Designee for all residents currently on hospice and receiving a controlled substance on____11/30/2023_____ . At an in-service held by the DON/Designee on 11/30/23 for all nurses and qualified medication aides the following was reviewed: 1. following physician orders and hospice care 2. medication administration 3. EMAR documentation Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. An audit of all residents was completed for medication availability and unavailable medications were corrected. The Director of Nursing or Designee will utilize QA tool entitled “F755 Pharmacy Services”. This monitoring tool will be utilized for 10 random residents for administration of medications and availability 5 days a week for four weeks, then 5 random residents 3 days a week for four weeks, then 3 random residents	

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	There shouldn't be any blanks in the EMAR/ETAR. There should always be an explanation as to why something wasn't administered. If the hospice nurse brought medication into the facility and there was an order for the medication, then it would be available to give. The current facility policy titled, "MEDICATION ADMINISTRATION", dated February 2017, was provided by the Administrator on 11/14/23 at 10:39 A.M. The policy indicated, "...To administer all medications safely and appropriately to aid residents to overcome illness, relieve, and prevent symptoms, and help in diagnosis...Return to the medication cart and document medication administration with initials in appropriate spaces on Medication Administration Record [MAR]...Circle initials on MAR if medication is not administered as ordered and record reason in the PRN [as needed]/Omission Medication section of the MAR..." This tag relates to Complaint IN00418816. 3.1-25(a)		once a week for four months. Any concerns will be immediately addressed and corrected. If the facility is within 95% compliance at the end of 6 months, the monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC: 11-30-2023**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection			

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	prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the			

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	disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines for residents who were under isolation precautions for Covid-19. (Residents L and H) Findings include: 1. During an observation on 11/13/23 at 2:28 P.M., CNA (Certified Nurse Aide) 2 went to answer a call light for Resident L's room. The CNA donned an N-95 mask from an isolation cart sitting in the hallway and entered Resident L's room. The CNA failed to don a gown, gloves, or clean his hands. He wore his own glasses. The sign posted on the outside of the room door indicated the resident was in Droplet/Contact Isolation and prior to entering the room staff were to clean their hands, don a gown, gloves, mask, and eye protection. The resident was sitting near the door to the room watching a television that sat on a small dresser.	F 0880	**F 880 – Infection Prevention & Control** It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease. All residents residing in the facility have the potential to be affected. Staff members of focus now use proper PPE technique when caring for residents. At an in-service for all staff held on 11/30/2023 and conducted by DON/Designee, the following was reviewed: 1.Transmission based precaution guidelines related to Covid-19	11/30/2023

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	During an interview on 11/13/23 at 2:30 P.M., CNA 2 indicated if they were going into an isolation room, just to shut off the call light or bring in ice water and not providing patient care, he wore a mask and gloves. If he was providing patient care he wore a gown, mask, face shield, and gloves. He believed it was just the resident in the first bed, Resident L, who was positive for Covid-19, at that time. During an observation on 11/13/23 at 2:39 P.M., CNA 2 was wearing an N-95 mask and gathering trash from Resident L's room. The trash was in a clear bag and the CNA was placing it in a red isolation bag. The CNA was not wearing a gown or face shield. The clinical record for Resident L was reviewed on 11/14/23 at 11:25 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/28/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cancer, fracture, anxiety, and depression. The current list of residents who had recently tested positive for Covid-19 indicated Resident L had tested positive on 11/09/23, and would be out of isolation on 11/20/23. 2. During an observation and interview on 11/14/23 at 9:11 A.M., with the Administrator, a group of residents were sitting outside the window to the Administrator's office on the front patio of the facility smoking. CNA 3 was sitting with the residents and wearing an N-95 mask as she assisted the residents. The CNA wore no gown, gloves, or face shield. The Administrator identified the residents as Resident H, Resident L, and Resident K, all of which were currently		2. donning and doffing PPE Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. The IP nurse/DON/Designee will complete visual rounds throughout the facility and observe 10 staff members weekly to ensure they are preforming transmission-based precautions x 4 weeks, then 5 staff members weekly x 4 weeks, then 1 staff member monthly x 4 months. Any concerns will be addressed immediately. If facility is within 95 % compliance at the end of 6 months; then monitoring can be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **DOC: 11/30/2023**	

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	positive for Covid-19. CNA 3 was holding new cigarettes in between her bare fingers for the residents, passing them out, and lighting them. The CNA and residents were all within six feet of one another. During an observation on 11/14/23 at 12:50 P.M., a sign posted on the front of the exterior door to the facility indicated the facility was in outbreak status and had 19 residents and 10 staff members who were currently positive for Covid-19. The isolation precaution signs posted on the residents' room doors who were positive for Covid-19 were provided by the RDO (Regional Director of Operations) on 11/14/23 at 10:55 A.M. The signs indicated the residents were in Droplet/Contact Isolation and prior to entering the room staff were to clean their hands, don a gown, gloves, mask, and eye protection. During an interview on 11/14/23 at 11:00 A.M., the RDO indicated for residents in Contact/Droplet Isolation who had tested positive for COVID-19, the staff should don a gown, gloves, N-95 mask, and a face shield, glasses, or goggles prior to entering the residents' rooms. The current list of residents who had recently tested positive for Covid-19 indicated Resident H had tested positive on 11/13/23, and would be out of isolation on 11/24/23. The current "Post Public Health Emergency - Standard and Guidelines" policy, with an effective date of 05/23/23 was provided by the RDO on 11/14/23 at 11:03 A.M. The policy indicated, "...The facility will follow CDC [Centers for Disease Control] guidelines including prompt detection, triage and isolation of potentially			

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	infectious residents to prevent unnecessary exposures of COVid-19 [sic]...The facility will provide education and visual alerts (signs, posters) to ensure everyone is aware of recommended IPC [Infection Prevention Control] practices in the facility. This includes making everyone entering the facility aware of the recommended action to prevent transmission...HCP (Health Care Providers) who enter the room of a resident with suspected or confirmed SARS-CoV-2 [Covid-19] infection will follow Transmission Based Precautions and use a NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection..." 3.1-18(b)(2)			