STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427231 and IN00429774. Complaint IN00427231 - Federal/state deficiencies related to the allegations are cited at F559. Complaint IN00429774 - No deficiencies related to the allegations are cited. Survey dates: March 8 and 11, 2024. Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census Bed Type: SNF/NF: 47 SNF: 2 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 38 Other: 7 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 13, 2024.	F 0000		
F 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryce Tomasi	Administrator	03/22/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. Based on observation, interview, and record review, the facility failed to involve the resident prior to a room change, resulting in the resident worrying about her personal property being damaged, for 1 of 3 residents reviewed for quality of care. (Resident B) Findings include: During an interview with Resident B in her room on the memory care unit, on 3/8/24 at 11:27 a.m., she indicated she had to move rooms after her previous room had flooded. She was trying to get some of her clothes back that she thought were still down in her old room, but was not sure where they were now. She liked to go to activities, and she had friends at her table during meals and in the social room. She was an artist; she liked to color and stay busy. She was upset when she first moved, but she had made some friends, and it was working out for her. Resident B's clinical record was reviewed on 3/8/24 at 9:26 a.m. Diagnoses included major depressive disorder, recurrent, moderate, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.	F 0559	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 3-18-2024. The facility is respectfully requesting paper compliance for all deficiencies in this POC. **F 559 It is the intent of this facility to involve the resident prior to a room change.** What corrective action will be accomplished for those residents found to have been affected by the deficient practice: **Resident B was assessed by the SSD on 3-18-2024 for psychosocial issues related to room change, with no negative outcome. How other residents**	03/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A 11/5/23 elopement risk assessment indicated she was not at risk for an elopement. A 11/7/23 wandering risk assessment indicated she was at a high risk for wandering. A quarterly Minimum Data Set (MDS) assessment, dated 12/15/23, indicated she was moderately cognitively impaired. She wandered one to three days during the assessment period. She had a current care plan for wandering. She often wandered related to cognitive impairments, feeling lost, her inability to locate her room, and she sought family members/friends (11/13/23). Her interventions included she wandered only within specified boundaries (11/13/23), assist her to/from activities, seat her close to the speaker to encourage involvement (11/13/23), place familiar objects next to her in her room such as pictures/objects/furniture (11/13/23), provide assistance in locating her room (11/13/23), provide directional cues (i.e. pictures, name on doors) (11/13/23), remove items that may trigger her to leave the facility (i.e. coat, gloves, hat) (11/13/23) and take a picture for the elopement book (2/19/24). She had a current care plan for memory care, as she resided in the memory care unit. She had a dementia diagnosis and benefited from the programming on this unit. Although it was a secured unit, she was able to come off the unit for special activities she enjoyed with staff/family, as desired (1/9/24). Her interventions included she participated in programming on the memory care unit (1/9/24), physician has certified her as appropriate for this unit and programming (1/9/24), she was independently mobile; either ambulatory,		**having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator/Designee educated the Social Services on room change notification and documentation policy "Room Assignments and Changes" on (3-18-2024). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated.The DON/Designee educated the nursing staff of room change notification and documentation. Policy "Room Assignments and Changes" on (3-18-2024). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	using walker/or with a wheelchair (1/9/24), and she/family were aware when she no longer participated/benefited in programming, a relocation conference would be initiated (1/9/24). Review of nurses notes indicated the following: On 12/15/23 at 10:41 p.m., her daughter agreed for her to join activities and programming in the memory care unit to establish a routine due to increased confusion and increased need with explaining Activities of Daily Living (ADLs). The nursing staff were to guide her to group activities and back to the memory care unit following the activity, and she was to attend the next meal on the unit. Nursing was to document moods/contentment on the memory unit. Social Service was to visit her as needed. A late entry nurses note, dated 12/20/23 at 10:31 a.m. and created on 1/2/24 at 10:32 a.m., indicated she walked up and down the hallway stating she needed to know where her roommate was. She was not easily directed. A late entry nurses note, dated 12/28/23 at 8:32 a.m. and created on 1/2/24 at 10:33 a.m., indicated she walked out of her room without shirt or bra on, and she yelled for her previous roommate. Staff immediately assisted her back in her room and assisted her to get dressed. On 12/28/23 at 10:47 a.m., she was more and more confused. She was in the hall going the wrong way looking for the main dining room. She yelled at the staff that she knew where she wanted to be and they needed to stop moving the rooms. On 12/30/23 at 5:12 a.m., she woke up very confused, stating she didn't know if she had slept		**assurance program will be put into place:** Administrator/Designee will monitor room changes for notification of resident and resident responsible party 5 times a week x 4 weeks, then 3 times a week x weeks, then once a week x 4 months. If **the facility is within 95% compliance at the end of the 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 the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed: 3-18-2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at all. She did not know what time it was or where she was. She was very confused as to why she was no longer in her pajamas. The CNA explained to her that she had changed herself into her daily clothes and that she did sleep. She was still confused, but accepted what the CNA said. On 1/1/24 at 2:34 p.m., she tried to open the exit door and she was not easily redirected. On 1/2/24 at 10:35 a.m., her POA was called and it was offered to move Resident B to the secured memory care unit. They agreed. On 1/6/24 at 1:04 a.m., she was moved to a room in another area (the secured memory unit) and tolerated the change well. She was a bit confused as to why they moved her away from her friends, but didn't complain much about the change. The clinical record lacked prior notification to or involvement of the resident in the room change. The clinical record lacked notification to her representative in writing of the room change. During an interview with QMA 8, on 3/8/24 at 11:19 a.m., she indicated management had told Resident B that her old room had flooded, and that was why she was moved to the memory care unit. They told her this because she wouldn't have moved. She didn't like change. She did not have the conversations and stimulation like she did when she was on the other hall. During an interview with LPN 16, on 3/8/24 at 11:54 a.m., she indicated before Resident B moved to the memory care unit, she had increased confusion. She would come out of her room and didn't know where the dining room was. She exit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sought a couple of times. During an interview with the ADON and DON, with the Administrator present, on 3/8/24 at 11:59 a.m., the ADON indicated Resident B's family had agreed to move her. She told her that her toilet had flooded a little and unfortunately, she remembered it. The DON indicated the ADON made the mistake of telling her that her room flooded. The family wanted her to move during lunch. The ADON indicated her family and the previous Social Service Director had a plan for her to go on day visits to the memory care unit, but the other managers were not aware of this plan. The DON indicated she felt that type of plan confused the residents even more by doing the day visits. The ADON had apologized over and over for saying that her room was flooded. Her legs/feet hurt because she walked so much when she was in her old room. Her daughter later told her she felt she was bullied to make her move to the memory care unit. The family was given a choice for Resident B to have a roommate or to move to a room by herself in the memory care unit. They offered to move her back to her old room, but the family was happy, and didn't want to move her back. During an interview with the Activity Director, on 3/11/24 at 9:42 p.m., she indicated Resident B normally came out of the memory care unit for activities. When she first got moved to the memory care unit, she was very upset about moving and the flood, but there never was a flood. Resident B had said she didn't understand why she had to move, there wasn't a flood before she had gone to lunch. During an interview with the Social Service Director, on 3/11/24 at 10:48 a.m., she indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she had been with the facility less than 90 days. When a resident changed rooms, she would notify the family and the resident, she would talk to them to make sure the transition went smooth, then she followed up with them to make sure things were going good and document it. A Notification of Room Change evaluation was supposed to be completed when a resident was moved. There was not one completed for Resident B, but there was a progress note. They didn't normally have the POA sign for a room change, they put it in a progress note. If she was to move someone to the memory care unit, she would trial the resident in the unit. Resident B was thriving, and she came out of the memory care unit for activities. Resident B had never brought up the flooding to her, she had not even heard about it until 3/8/24, but sometimes you had to live in "their world." During an interview with the Housekeeping/Laundry Supervisor, on 3/11/24 at 11:21 a.m., she indicated typically she knew in advance when a resident was going to move rooms. The day Resident B was moved she walked through the memory care unit and the ADON, DON, and Administrator stood at the room where Resident B was going to be moved to. They indicated they were going to move Resident B during lunch before her family changed their mind. A current facility policy, revised 7/14, titled "Room Assignment and Changes," provided by the Administrator on 3/11/24 at 12:09 p.m., indicated the following: "...Room Change...Room transfers will only be initiated upon the request of the Resident/responsible party or in the event that the current accommodations do not satisfy the Resident's psychosocial or care needs. If it is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	determined that the medical/treatment needs of the Resident no longer require or cannot be met in the current location, the Resident and/or responsible party will be notified. A transfer will be encouraged in order to meet the Residents' needs in the most efficient manner available...The Director of Social Services will orient the Resident and/or responsible party to new room and surroundings PRIOR to change. Introductions will involve both Residents and their responsible parties to the degree possible...All information regarding the move, including proof of medical necessity or special compelling circumstances, will be thoroughly documented by all involved disciplines in the Resident's clinical record. "Notice of Room Change"...must also be utilized. 3.1-3(v)(2) This citation relates to Complaint IN00427231.			