STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00428580, IN00433065, IN00435133, and IN00442971. Complaint IN00428580 - Federal/State deficiencies related to the allegations are cited at F727. Complaint IN00433065 - Federal/State deficiencies related to the allegations are cited at F727. Complaint IN00435133 - No deficiencies related to the allegations are cited. Complaint IN00442971 - No deficiencies related to the allegations are cited. Survey dates: October 2, 3, 4, 7, and 8, 2024 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 1 Medicaid: 39 Other: 9 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	F000 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 October 26, 2024. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	

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

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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F 0550 SS=D Bldg. 00	Quality review completed on October 9, 2024. 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure a resident's dignity was maintained by not sitting down while assisting a resident with eating for 1 of 1 resident randomly observed during dining. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 10/7/24 at 11:00 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated cognitive impairment. An Activities of Daily Living (ADL) care plan, revised 12/22/23, indicated she needed assistance with eating. An observation was conducted of Resident 2 in the dining room on 10/7/24 at 12:35 p.m. The resident was observed sitting at a table in the dining room. Certified Nursing Assistant (CNA) 1 was standing next to the resident's table assisting the resident with eating her meal. An interview was conducted with the Nurse Consultant (NC) on 10/7/24 at 3:30 p.m. She indicated CNA 1 should have been sitting while assisting Resident 2 with her meal. A resident rights policy was provided by the NC on 10/8/24 at 10:14 a.m. It indicated, "...7) It is	F 0550	F550 It is the policy of the facility to ensure the residents dignity is maintained and staff sit while assisting residents with eating. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The SSD/Designee assessed Resident # 2, no negative psychosocial side effects noted from this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies 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 the deficient practice does not recur.** The Director of Nursing or designee completed education with nursing staff on to sit until assisting residents with meals to maintain dignity. Additionally, any	10/26/2024

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	important that staff be aware of the resident rights to include, but not limited to...A dignified existence - resident being treated with dignity in all situations...To achieve this --staff will...1) Treat each resident with respect and dignity. 2) Care for each resident in a manner and environment that promotes the maintenance of/or enhances the resident's quality of life..." 3.1-3(t)		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 will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** Feeding QA Audit Form will be completed on 10 random residents during random meal services weekly x 4 weeks, 5 random residents weekly x4 weeks, and then 3 random resident monthly 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 deficient will be completed.** 10/26/2024	
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on interview and record review, the facility	F 0565	F565 It is the policy of this facility to	10/26/2024

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	failed to timely address a resident's grievance for 1 of 1 resident reviewed for choices. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed on 10/3/24 at 9:00 a.m. The diagnoses included, but were not limited to, stroke. A quarterly Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated Resident 11 was cognitively intact. An interview was conducted with Resident 11 on 10/3/24 at 9:41 a.m. He indicated he had been storing a Tupperware container that contained his tea pot and tea bags in a cabinet in the dining room for years. He was told a couple of days ago; he no longer was allowed to do that anymore. He had to store the Tupperware container in his room and take it back-an-forth from his room to the dining room every meal. It made it difficult. He was never given a reason why he could no longer store the container in the dining room. The resident had told everyone he was not happy about it. He had worked really hard to be able to use his crutches, but now he had to get back in the wheelchair. He cannot take his Tupperware container to the dining room with his crutches. An interview was conducted with the Activities Director on 10/7/24 at 2:49 p.m. She indicated Resident 11 was unhappy he was unable to store his teapot and tea bags in the dining room. He had stored the Tupperware container in the dining room for years, but was told, either 9/30/24 or 10/1/24, he was no longer able to store it there. He would use an exercise band strapped to his wheelchair to take his Tupperware container back-an-forth to the dining room. She did not fill		address grievances timely. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 11 grievance was resolved to resident's satisfaction by the ADM/Designee on 10/7/2024. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The Administrator/Designee completed a 90 day look back of grievances for follow up/resolution with resident on 10/23/2024. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service Director/designee completed education with all staff on 10/23/2024 related to grievance policy. Resident will be educated of grievance policy during resident council on 10/25/24. Additionally, any employee who fails to comply with the points of the in-service	

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	out a grievance form about the resident's concern. A grievance policy was provided by the Administrator on 10/8/24 at 10:24 a.m. It indicated, "... Purpose: To provide a 'process' by which a resident or resident's representative can have their questions/concerns brought to the proper source to be answered/addressed and resolved as much as possible to the satisfaction of the resident or their representative and to have this activity documented including: A. Question and Details B. Action taken (and by whom) C. Dates/Times D. Response back to resident/representative E. Documentation complete F. Filing in 'I would Like to know'... binder. Procedure: 1. When a resident or a resident's representative presents a question/concern, a staff member obtains the 'I would like to know'... form. A staff member completes the form for the resident or the resident's representative. If possible, a leadership staff person should complete the form. The form is then deposited into a designated secure area...3. During the following morning meeting, the Administrator or designee reads the 'I would like to know'... form to the CQI [Continuous Quality Improvement] committee and logs the questions/concern on the tracking form. 4. The Department Head(s) who is designated by the Administrator/CQI Committee to be the appropriate person(s) to address the question/concern will be provided a copy of the 'I would like to know form'... 6. At the CQI meeting, the Administrator or designee will review the log and the status of the unanswered questions/concerns will be discussed. The objective being to answer all logged questions/concerns as soon as possible. 7. The assigned Department Head should be prepared to share what has been done to date to answer/resolve the question/concern...10. When		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 assurance program will be put into place.** The SSD/Designee will interview 10 random residents weekly x 4 weeks, then 5 random residents weekly x weeks, then 3 random residents weekly x 4 weeks, then 3 random residents monthly x 3 months for any concerns and a grievance form will be completed and follow up/resolution will be completed by appropriate department. The Administrator/Designee will audit grievances for follow up/resolutions and resident notification weekly x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 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	

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	the question/concern has been answered or has been resolved to the greatest degree possible, the assigned Department Head will contact the appropriate party to discuss what has been done. It is important that the resident or the resident's representative understands and agrees with or accepts the 'answer' as being to their satisfaction..." 3.1-7(a)(2) 3.1-7(b)		weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** October 26, 2024	
F 0641 SS=B Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 4 of 7 residents reviewed for MDS accuracy (Resident 1, 12, 22, and 42). Findings include: 1. The clinical record for Resident 1 was reviewed on 10/7/24 at 12:31 p.m. The diagnoses included, but were not limited to, paraplegia. The Admission MDS assessment, dated 8/18/24, indicated Resident 1 had bed rails used as a restraint daily. 2. The clinical record for Resident 12 was reviewed on 10/7/24 at 12:40 p.m. The diagnoses included, but were not limited to, dementia. The Quarterly MDS assessment, dated 9/13/24, indicated Resident 12 had bed rails used as a restraint daily. 3. The clinical record for Resident 22 was	F 0641	**F641** It is the policy of this facility to ensure the MDS assessment is coded accurately. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #1 MDS dated 08/18/2024 was corrected on 10/07/2024 to indicate no restraints, by the MDS Nurse/Designee. Resident #12 MDS dated 09/13/2024 was correct on 10/07/2024 to indicate no restraints by the MDS Nurse/Designee. Resident #22 MDS dated 08/31/2024 was corrected on 10/07/2024 to indicate no restraints by the MDS Nurse/Designee. Resident #42 MDS dated	10/26/2024

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	reviewed on 10/7/24 at 12:48 p.m. The diagnoses included, but were not limited to, hypertension. The Quarterly MDS assessment, dated 8/31/24, indicated Resident 22 had bed rails used as a resident daily. 4. The clinical record for Resident 42 was reviewed on 10/7/24 at 12:55 p.m. The diagnoses included, but were not limited to, depression. The Admission MDS assessment, dated 9/11/24, indicated Resident 42 had bed rails used as a restraint daily. During an interview on 10/7/24 at 2:38 p.m., the Minimum Data Set Coordinator (MDSC) indicated that the MDS assessments had been coded inaccurately and the bed rails used were enables for bed mobility, not as restraints. During an interview on 10/7/24 at 2:40 p.m., The Regional MDSC indicated the facility used the Resident Assessment Instrument (RAI) Manual as the policy.		09/11/2024 was corrected on 10/7/2024 to indicate no restraints by the MDS Nurse/Designee. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The MDS Coordinator/designee completed a 90-day lookback 10/23/24 on residents who have siderails to verify MDS accuracy, any incorrect coding was modified on 10/24/2024. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** MDS Consultant/designee completed education with MDS Coordinator on 10/23/24 related to accuracy of MDS assessments. 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 will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place** *The DON/Designee will audit residents MDS assessment for accurate coding related to bed rails weekly x 6 months. If the facility is within 9% complaint after 6 months, the monitoring will be*	

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			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 deficient will be completed.** 10/26/2024	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to administer medications and collect urine samples as ordered, to timely schedule a follow-up appointment for a resident who was admitted with a healing leg fracture, and timely implement dietary recommendations for a resident with a feeding tube for 1 of 1 resident reviewed for mobility, 1 of 1 resident reviewed for feeding tubes, and 3 of 5 residents reviewed for unnecessary medications. (Resident 11, Resident 29, Resident 30, Resident 42, and Resident 95) Findings include: 1. The clinical record for Resident 42 was reviewed on 10/3/24 at 1:18 p.m. The diagnoses included, but were not limited to, fracture of the lower femur (thighbone) and depression. She was admitted to the facility on 9/4/24.	F 0684	F684 It is the policy of the facility to administer medications, collect urine samples, schedule follow up appointments, implement dietary recommendations for residents with tube feeding timely. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #42 had follow up orthopedic appointment scheduled for 10/10/2024. This appointment was cancelled by resident #42 son and is now rescheduled for 10/28/2024, the DON/Designee. Resident #30 had order placed in EHR on 10/17/2024 for weekly	10/26/2024

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	A physician's progress note, dated 9/10/24, indicated Resident 42 had recently admitted to the facility. She had a previous stay at another rehabilitation facility following a right femur fracture on 7/26/24. An Admission Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident 42 had severe cognitive impairment and was dependent on staff for bed mobility and lower body dressing. A physician's order, dated 9/17/24, indicated the right leg brace was to be monitored each shift for damage and wetness. The skin under the brace was to be monitored for open areas, redness, swelling, or any trouble moving toes. A physician progress note, dated 9/18/24, indicated she had received non-surgical care for her right femur fracture and continued to use a knee immobilizer. An orthopedic follow-up appointment was needed. During an interview on 10/3/24 at 2:59 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident 42 had worn the brace on her right leg since being admitted to the facility and she thought there was an orthopedic appointment coming up soon. On 10/7/24 at 9:33 a.m., LPN 4 was observed talking on the phone at the nurses' station, inquiring about making an appointment for Resident 42 to see an orthopedic doctor. During an interview on 10/7/24 at 9:37 a.m., LPN 4 indicated she had just made an appointment for Resident 42 to see the orthopedic doctor for a follow-up appointment. LPN 4 was unsure why		weights to be obtained per dietary recommendation by the DON/Designee. Resident #11 urine was collected on 09/26/2024. Resident #29 has new order for Metoprolol Succinate ER 50mg daily received on 10/14/2024 and prn Clonidine order was discontinued on 10/18/2024, by the DON/Designee. Resident #29 degludec insulin order was updated on 10/14/2024 to include parameters on when to hold medication. Resident #29 insulin lispro orders were updated on 10/11/2024 to include parameters on when to hold medication by DON/Designee. Resident #95 urine was collected on 10/18/2024 by the DON/Designee. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** DON/designee completed a 30 day look back on 10/23/24 related to physician progress notes and dietary recommendations to confirm all recommendations have been completed. DON/Designee completed a 30 day look back on 10/23/24 related to physician orders and to confirm urine collection orders have been	

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	the appointment had not been previously scheduled. During an interview on 10/7/24 at 2:14 p.m., the Director of Nursing (DON) indicated the facility should have attempted to make the follow-up orthopedic appointment for Resident 42 sooner. 2. The clinical record for Resident 30 was reviewed on 10/2/24 at 3:25 p.m. The diagnoses included, but were not limited to, epilepsy and dysphagia (inability to swallow). A care plan, last revised 11/8/23, indicated Resident 30 had a nutritional problem related to having a gastric tube (g-tube) provide all hydration and nutritional needs. The goal was for him to maintain his weight to within ten percent of his ideal body weight range. The interventions included, but were not limited to, the registered dietician to evaluate feedings and flushes as needed for weight changes and skin issues. The registered dietician would make recommendations as needed. Resident 30's weight, on 7/9/24, was 188.4 pounds. His weight, on 8/5/24, was 193.4 pounds. A Nutritional Assessment, dated 8/21/24, indicated he received Jevity (type of nutritional feeding) at 80 milliliter (ml) an hour continuously. He was dependent on tube feedings for nutrition and had a possible significant weight gain. The plan was to continue the tube feedings as ordered and to continue following weights and lower tube feeding if weight gain persisted. A SWAT (Skin Weight Assessment Team) note, dated 9/18/24, indicated his most recent weight, done on 8/5/24, was 193.4 pounds. He was to		completed. DON/Designee reviewed all current insulin and BP medication orders on 10/23/24 to confirm all orders have hold parameters in place per physician order. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** /p> **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON/Designee will audit Scheduling follow up appointments, following dietary recommendations, collecting urine samples, and BP medication and Insulin hold parameters audit will be completed 5 days a week x 4 weeks, weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance after the 6 months, the monitoring will 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	

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	continue to be monitored, and the Registered Dietician (RD) had requested weekly weights. A SWAT note, dated 9/25/24, indicated his most recent weight, done 8/5/24, was 193.4 pounds. The RD had requested a weekly weight be completed. A SWAT note, dated 10/2/24, indicated his most recent weight, done 8/5/24, was 193.4 pounds. The RD had requested a monthly and weekly weights be completed. The clinical record did not contain a weight for September 2024. During an interview on 10/8/24 at 9:30 a.m., Nurse Consultant (NC) 1 indicated Resident 30's October monthly weight was 198.7 pounds. There was not a September weight recorded. During an interview on 10/8/24 at 10:49 a.m., NC 1 indicated weekly weights should have been completed as recommended by the RD. On 10/8/24 at 10:49 a.m., NC 1 provided the S-W-A-T Program Meeting Guidance, dated 10/9/23, which read "...Intent: It is the intent of the facility to assess the nutritional status as well as the skin condition status of each resident and to timely address any issues or any potential for issues related to weight and /or skin... Procedure...5 Interventions decided upon by the team will be recorded on the individual resident monitoring record form. The appropriate disciplines will address interventions determined by the team..." 3. The clinical record for Resident 11 was reviewed on 10/3/24 at 9:00 a.m. The diagnoses included, but were not limited to, stroke.		written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** 10/26/2024	

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	155271	A. BUILDING 00 B. WING	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

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	A physician order, dated 9/3/24, indicated "Collect urine for urine culture to be picked up on 9/16/24 lab day." The start date was 9/15/24. A physician order, dated 9/3/24, indicated "Fax urine culture results to Urology of Indiana...every shift...for 4 days may dc [discontinue] this order when completed." The start date was 9/16/24. The September 2024 Medication/Treatment Administration Record indicated, on 9/18/24 and 9/19/24, Resident 11's urine was not collected. An interview was conducted with the Nurse Consultant on 10/7/24 at 3:00 p.m. She indicated Resident 11's urine was not collected as ordered. 4. The clinical record for Resident 29 was reviewed on 10/3/24 at 2:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and hypertension. A diabetes care plan, dated 11/27/23, indicated the resident was to receive diabetic medication as ordered. A hypertension care plan, dated 11/27/23, indicated the staff was to administer medications as ordered. A physician order, dated 4/10/24, indicated the resident was to receive 25 milligrams of metoprolol (blood pressure medication) once daily. A physician order, dated 4/10/24, indicated the resident was to receive six units of lispro insulin (fast acting insulin) with each meal. A physician order, dated 6/27/24, indicated the resident was to receive eight units of degludec			

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	insulin (long acting insulin) twice a day. A physician order, dated 8/23/24, indicated the resident was to receive 0.2 milligrams of clonidine every four hours, if the systolic blood pressure was greater than 160, as needed. The September 2024 Medication Administration Record for Resident 29 indicated the following: The resident's systolic blood pressure was greater than 160, and he did not receive the 0.2 milligrams of clonidine on the following days: - 9/2/24 - blood pressure reading 163/73, - 9/7/24 - blood pressure reading 173/72, - 9/9/24 - blood pressure reading 193/84, - 9/10/24 - blood pressure reading 188/86, - 9/15/24 - blood pressure reading 180/93, - 9/19/24 - blood pressure reading 161/72, - 9/26/24 - blood pressure reading 183/78, and - 9/28/24 - blood pressure reading 167/81, The following days the resident's degludec insulin was not administered as ordered: - 9/4/24 - a.m. dosage, - 9/6/24 - a.m. dosage, - 9/7/24 - a.m. dosage, - 9/13/24 - a.m. dosage, - 9/18/24 - a.m. dosage, - 9/20/24 - a.m. dosage, - 9/24/24 - a.m. dosage, - 9/26/24 - a.m. dosage, and - 9/30/24 - a.m. dosage. The following days the resident's lispro insulin was not administered as ordered: - 9/3/24 - 8:15 a.m. dosage,			

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	- 9/4/24 - 8:15 a.m. dosage, - 9/5/24 - 8:15 a.m. dosage, - 9/6/24 - 8:15 a.m. dosage, 12:30 p.m. dosage, 5:30 p.m. dosage, - 9/7/24 - 8:15 a.m. dosage, - 9/9/24 - 8:15 a.m. dosage, - 9/13/24 - 8:15 a.m. dosage, - 9/15/24 - 8:15 a.m. dosage, - 9/16/24 - 8:15 a.m. dosage, - 9/17/24 - 12:30 p.m. dosage, - 9/18/24 - 8:15 a.m. dosage, - 9/19/24 - 8:15 a.m. dosage, 5:30 p.m. dosage, - 9/20/24 - 8:15 a.m. dosage, - 9/21/24 - 12:30 p.m. dosage, - 9/22/24 - 8:15 a.m. dosage, - 9/23/24 - 8:15 a.m. dosage, - 9/24/24 - 8:15 a.m. dosage, 5:30 p.m. dosage, - 9/25/24 - 8:15 a.m. dosage, - 9/26/24 - 8:15 a.m. dosage, - 9/27/24 - 8:15 a.m. dosage, - 9/29/24 - 8:15 a.m. dosage, and - 9/30/24 - 8:15 a.m. dosage. Resident 29's clinical record did not include parameters when to hold the resident's insulin nor documentation the medical provider was notified with clarification to hold the resident's insulin. An interview was conducted with the Nurse Consultant on 10/7/24 at 9:00 a.m. She indicated the nursing staff should be notifying the medical provider to hold Resident 29's insulin due to low blood sugars and the 0.2 milligrams of clonidine should have been administered if the resident's blood pressure results were greater than 160. She will have the medical provider review the clonidine order. 5. The clinical record for Resident 95 was reviewed on 10/4/24 at 1:21 p.m. The diagnoses included,			

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	but were not limited to, chronic kidney disease and Alzheimer's disease. A progress note, dated 9/17/24, indicated the resident's representatives provided physician orders to obtain a urine albumin/creatinine ratio (a test that measures how much protein in urine) lab. The urine sample will be picked up on 9/20/24. A physician order, dated 9/17/24, indicated the staff was to collect urine for an albumin-creatine ratio. The urine sample would be picked up on 9/20/24. Resident's 95 medical record did not include documentation the urine sample was obtained. An interview was conducted with the Nurse Consultant on 10/7/24 at 3:00 p.m. She indicated Resident 95's urine sample was not collected as ordered. A following physician orders policy was provided by the Nurse Consultant on 10/8/24 at 10:14 a.m. It indicated, "...Policy: It is the policy of the facility to follow the orders of the physician...Procedure...4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received." 3.1-37(a)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to have a Registered Nurse (RN) on duty for	F 0727	F727 It is the intent of this facility to have an RN on duty at least eight	10/26/2024

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	at least eight consecutive hours a day, seven days a week. This had the potential to affect 49 of 49 residents in the facility. Findings include: The Payroll Based Journal (PBJ) Staffing Data Report for the third quarter of the 2024 Federal Fiscal Year indicated the facility had no RN coverage hours on the following dates: 4/7/24, 4/20/24, 4/21/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. On 10/3/24 at 10:20 a.m., the Administrator provided the Daily Nursing Schedule for the above dates. They, along with the time sheets for RN 9 provided by the Director of Nursing (DON), on 10/4/24 at 10:45 a.m., indicated there was no RN coverage on Saturday, 4/20/24, and Sunday, 4/21/24, but the schedule and time sheets did verify RN coverage for 4/7/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. An interview was conducted with the Staffing Coordinator (SC) and the DON on 10/3/24 at 11:28 a.m. The SC indicated she'd been the staffing coordinator for almost three years. The facility did not have RN coverage on 4/20/24 and 4/21/24. RN 9 was the facility's RN weekend option nurse, but she did not work on those dates, and they hadn't used agency nursing staff since 4/1/24. The DON indicated he worked Monday through Friday, and only worked weekends sometimes. An interview was conducted with the Nurse Consultant (NC) on 10/4/24 at 11:55 a.m. She indicated they had no facility policy regarding RN coverage.		consecutive hours a day seven days a week. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified for this cited deficient practice. **how other residents 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 deficient practice, therefore, this plan of correction applied to all residents that resident in the facility. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing/designee completed education with scheduler on 10/23/2024 related to CMS guideline on RN coverage requirement. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated.	

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	This citation relates to Complaints IN00433065 and IN00428580. 3.1-17(b)(3)		**how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** *The DON/Designee will Audit of RN coverage x 8 consecutive hours will be completed 5 times a week x 4 weeks then 3 times a week x 4 weeks, then once a week x 4 weeks, then once month x 3 months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped. Res*ults 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. October 26, 2024**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary	F 0812	F812	10/26/2024

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	Based on observation, interview, and record review, the facility failed to hold food on a steam table at safe temperatures with the potential to affect 48 of 49 residents residing at the facility. Findings include: On 10/4/24 at 12:41 p.m., the lunch service was observed in the facility's main kitchen with Facility Cook (FC) 1. FC 1 indicated he was serving the room trays. The steam table contained a serving pan of mixed vegetables and a serving pan of bourbon fish filets. The temperature of the mixed vegetables was obtained at 121.8 degrees Fahrenheit (F). The temperature of the bourbon fish fillets was obtained at 107 degrees F. FC 1 indicated the temperature of the mixed vegetables, and the bourbon fish filets should have been at least 135 degrees F. On 10/4/24 at 12:48 p.m., the lunch service was observed in the facility's upstairs kitchenette. FC 2 indicated he was finishing the upstairs dining room's food service. The steam table contained a serving pan of French fries. The temperature of the French fries was obtained at 120 degrees F. On 10/4/24 at 1:50 p.m., the Regional Director of Operations provided the Food Safety Handout, dated 9/28/2020, which read, "... Foods should be stored at appropriate temperatures to maintain safety...Hot foods held at 135 degrees Fahrenheit to 170 degrees Fahrenheit..." 3.1-21(a)(2)		It is the policy of this facility to hold food on the steam table at safe temperatures. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The DON/Designee assessed all residents on DATE and no negative outcomes identified. **how other residents 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 deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Dietary Manager in-serviced the dietary staff on Food Safety and food temperatures when using the steam table on DATE. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated **how the corrective**	

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			action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; *The Dietary manager will complete Food temperature QA Audit Form for 10 random meals weekly x 4 weeks, 5 random meals weekly x 4 weeks, and then 3 random meals monthly 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. October 26, 2024**	
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal Based on interview and record review, the facility	F 0851	**F851** **It is the intent of this facility to**	10/26/2024

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	failed to submit to Centers for Medicare and Medicaid Services (CMS) accurate direct care staffing information regarding the correct category of work for a Registered Nurse for 49 of 49 residents in the facility. Findings include: The Payroll Based Journal (PBJ) Staffing Data Report for the third quarter of the 2024 Federal Fiscal Year indicated the facility had no RN coverage hours on the following dates: 4/7/24, 4/20/24, 4/21/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. On 10/3/24 at 10:20 a.m., the Administrator provided the Daily Nursing Schedule for the above dates. They, along with the time sheets for RN 9 provided by the DON (Director of Nursing), on 10/4/24 at 10:45 a.m., indicated there was RN coverage on 4/7/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. An interview was conducted with the Staffing Coordinator (SC) and the DON on 10/3/24 at 11:28 a.m. The SC indicated she'd been the staffing coordinator for almost three years. RN 9 was the facility's RN weekend option nurse who worked on 4/7/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. RN 9 just became an RN in March 2024 and she was unsure if the system that sends in the PBJ data was updated to reflect RN 9's title change to an RN. Per https://mylicense.in.gov/everification/Search.aspx , RN 9's active RN license was issued effective		**submit to Centers or Medicare and Medicaid Services accurate direct care staffing information.** **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The errors identified on the payroll-based journal have been corrected by the Administrator. **how other residents 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 alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Administrator/Designee in-serviced the Business office manager on updating and submitting Employee Change Forms when a change in Licensure occurs on 10/23/24. Additionally, any staff members fails to comply with points of this	

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	3/21/24. An interview was conducted with the Nurse Consultant (NC) on 10/4/24 at 11:55 a.m. She indicated they had no facility policy regarding PBJ data submission.		in-service will be further educated and/or disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Administrator will audit employees with a licensure change and all new employees for correct job class coding weekly x 6 months. *If the facility is within 95% compliance after the 6 months, the monitoring will be stopped. Res*ults 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.** October 26, 2024	
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization			

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	Based on interview and record review, the facility failed to ensure 5 of 5 residents medical records included documentation that indicated the resident or resident representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the COVID-19 vaccine was administered to the resident; or whether the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal for 4 of 5 residents reviewed for COVID-19 immunization. (Residents 11, 18, 20, 24, and 30) Findings include: The clinical records for Residents 11, 18, 20, 24, and 30 were reviewed on 10/3/24 at 11:48 a.m. Resident 11 was admitted to the facility on 7/8/20. Resident 11's clinical record indicated he was last administered the COVID-19 vaccine on 7/7/22. There was no information in his clinical record that indicated Resident 11 or Resident 11's representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the 2023-2024 COVID-19 vaccine was administered to Resident 11; or whether Resident 11 did not receive the 2023-2024 COVID-19 vaccine due to medical contraindications or refusal. Resident 18 was admitted to the facility on 7/2/18. Resident 18's clinical record indicated she was last administered the COVID-19 vaccine on 7/6/22. There was no information in her clinical record that indicated Resident 18 or Resident 18's representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the	F 0887	**F887** It is the intent of this facility to ensure residents or residents representative are provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine, document in the EMR if the COVID-19 vaccine is administered or if the COVID-19 vaccine was declined or was not administered due to medical contraindications. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident #11 declined the COVID-19 booster on 10/3/24. Resident #18 declined the COVID-19 booster on 10/3/24. Resident #20 no longer resides in the facility, Resident #24 consented for the COVID-19 booster on 10/3/24 and received the booster on 10/23/24, Resident #30 consented for the COVID-19 booster on 10/4/24 and received the booster on 10/22/24, by the DON/Designee. The DON/Designee also provided education regarding risks and benefits associated with the vaccine and documented in the EMR for both administered and declined vaccines on DATE. **How other residents having the potential to be affected by the same deficient practice will be**	10/26/2024

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	155271	A. BUILDING 00 B. WING	10/08/2024

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	2023-2024 COVID-19 vaccine was administered to Resident 18; or whether Resident 18 did not receive the 2023-2024 COVID-19 vaccine due to medical contraindications or refusal. Resident 20 was admitted to the facility on 3/2/20. Resident 20's clinical record indicated he was last administered the COVID-19 vaccine on 7/6/22. There was no information in his clinical record that indicated Resident 20 or Resident 20's representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the 2023-2024 COVID-19 vaccine was administered to Resident 20; or whether Resident 20 did not receive the 2023-2024 COVID-19 vaccine due to medical contraindications or refusal. Resident 24 was admitted to the facility on 5/3/21. Resident 24's clinical record indicated she was last administered the COVID-19 vaccine on 7/6/22. There was no information in her clinical record that indicated Resident 24 or Resident 24's representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the 2023-2024 COVID-19 vaccine was administered to Resident 24; or whether Resident 24 did not receive the 2023-2024 COVID-19 vaccine due to medical contraindications or refusal. Resident 30 was admitted to the facility on 10/24/23. There was no information in Resident 30's clinical record that indicated Resident 30 or Resident 30's representative was provided education regarding the benefits and potential risks associated with the 2023-2024 COVID-19 vaccine; whether the 2023-2024 COVID-19 vaccine was administered to Resident 30; or whether Resident 30 did not receive the 2023-2024		**identified and what corrective action will be taken.** The Director of Nursing/designee obtained new consent/declinations for COVID-19 booster for current residents on 10/2/24. Current residents that consented to receive COVID-19 booster had orders placed in EHR on 10/23/24. Current residents had consents/declinations added to their EHR 10/23/24. Residents and/or resident representative received education reading he benefits and potential risks associated with the 2023-204 COVID-19 vaccine. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Director of Nursing/designee completed education on 10/23//24 with Licensed Nurses and Admissions related consent/declinations of the 2023-2024 COVID-19 vaccine, administering booster, and documenting in resident HER and providing education. 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 will be monitored to ensure the**	

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	COVID-19 vaccine due to medical contraindications or refusal. An interview was conducted with the Nurse Consultant (NC) on 10/4/24 at 10:45 a.m. She indicated they had no verification the 2023-2024 COVID-19 vaccination was offered, refused, medically contraindicated, or that education regarding the 2023-2024 COVID-19 vaccination was provided to Residents 11, 18, 20, 24, and 30. The NC provided the Post Public Health Emergency -Standard and Guidelines policy on 10/4/24 at 10:45 a.m. It read, "The facility will continue to encourage everyone to remain up to date with all recommended Covid-19 vaccine doses. Healthcare Personnel, residents and visitors will be offered resources and counseled as necessary about the importance of the Covid-19 vaccine. The facility will provide education and visual alerts (signs, posters) to ensure everyone is aware of recommended IPC [Infection Prevention and Control] practices in the facility." The policy did not reference documentation of a resident's clinical record regarding whether the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; whether the COVID-19 vaccine was administered to the resident; or whether the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.		**deficient practice will not recur, i.e what quality assurance program will be put into place:** *The DON/Designee will completed the COVID-19 consent/declinations order audit tool will be completed on new admissions and re-admissions for administering and documenting administration or declination and education provide in the EMR 5 days a week x 4 weeks,3 days a week, x 2 months, then weekly x 4 months. The DON/Designee will audit residents that have not received the 2023-2024 COVID-19 vaccine once a month x 6 months for consents and declinations and educations provided.* 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 deficient will be completed.** 10/26/2024	

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