| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--|---|--|--|---------------------|--|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 1600 E | ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F 0000 | | | | | | | |
| Bldg. 00 | Licensure Survey. | 55223 89650 | F 00 | 000 | Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections sat forth the statement of deficiencies. plan of Correction is prepared submitted because of requirements under State and Federal law. The facility reque paper compliance for this citat This Plan of Correction is the center's credible allegation of compliance. Facility respectful requests paper desk review. | e on This and sts ion. | |
| F 0623 SS=D Bldg. 00 | Quality review com 483.15(c)(3)-(6)(8 Notice Requireme Transfer/Discharg Based on record rev failed to ensure tran were completed and representative for a | pleted on October 17, 2024.) nts Before | F 06 | 523 | F623 Notice Before Transfer/Discharge It is the policy of this facility to ensure transfer and discharge documents are completed and provided to the resident representative for a discharge the hospital. 1 What corrective action(will be accomplished for those | to s) | 11/19/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Lisa Foreman Administrator 11/01/2024

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MNLH11 Facility ID: 000128 If continuation sheet Page 1 of 32

11/08/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/09/2024 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident 57's record was reviewed on 10/8/24 at residents found to have been 12:17 p.m. The profile indicated the resident's affected by the deficient diagnoses included, but were not limited to, practice? vascular dementia (a chronic condition that The Social Service occurs when blood flow to the brain is disrupted, Director/Designee sent written damaging brain tissue and affecting memory, notification of the thinking, and behavior). Transfer/Discharge policy on for resident 57 for 3/24/2024 A quarterly Minimum Data Set (MDS) hospitalization on 11/1/2024. assessment, dated 8/27/24, indicated the resident The DON/Designee notified the had severe cognitive deficit with no documented MD of the lack of order to send to behaviors. hospital on 3/24/2024 on 11/1/2024. A care plan, with a revised date of 3/25/24, How other residents indicated the resident exhibited socially having the potential to be inappropriate behavior and other socially affected by the same deficient inappropriate verbal behaviors, regarding staff of practice will be identified and what corrective action(s) will be taken? A progress note, dated 3/24/24 at 7:35 a.m., indicated a Certified Nursing Assistant (CNA) had All residents who reside in the reported that the resident had put her hands facility have the potential to be between a male resident's legs while sitting next to affected by the alleged deficient each other in the dining room. The resident's had practice. Therefore, this plan of been separated from one another, assessed by a correction applies to all residents nurse, and placed on 15 minute checks. of the facility. What measures will be A Social Service progress note, dated 3/24/24 at put into place and what 2:16 p.m., indicated Resident 57 had been referred systemic changes will be made to a Behavioral Health Care (BHC) hospital to ensure that the deficient following the incident with the male resident practice does not recur? earlier in the day. An in-service will be completed by the DON/Designee on 11/14/2024 A historical review of the resident's physician's for all nursing staff on the orders lacked documentation of an order to send transfer/discharge policy and the resident to the BHC hospital. entering orders to send to hospital in the EMR. Additionally, any staff The record lacked documentation that transfer that fails to comply with the points and discharge forms had been completed and of this in-service will be further provided to the resident's representative. educated and/or disciplined as

MNLH11

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| educated and/or disciplined as | | _ | | | | | <u> </u> | |
| | | earlier in the day. | | | | | | |
| | | A historical review | of the resident's physician's | | | - | | |
| orders lacked documentation of an order to send | | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/09/2024 | | |
|--|---|---|---------------------------------------|--|---|
| | ROVIDER OR SUPPLIER | | 1600 E | ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST IGTON, IN 47932 | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | (X5) COMPLETION |
| TAG | REGULATORY OR the resident to the B | LSC IDENTIFYING INFORMATION | TAG | 4 How the corrective | DATE |
| | The record lacked d policy had been con resident's representa During an interview | ocumentation that a bed hold inpleted and provided to the | | action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place: The DON/Designee will audit | e ty out |
| | facility had been un bed hold policy doc | able to locate the completed uments for the resident's BHC ne documents were required to | | residents transferred to the hospital to verify letter of bed policy was given to the reside | hold |
| | be completed and presponsible party are placed into the resident | rovided to the resident or ad a copy should have been dent's medical record. | | resident representative 5 times week x 4 weeks, then 3 times week x 4 weeks, then weekly months. If the facility is within | a a x 4 |
| | Consultant 18 provi titled, "Bed Hold," a currently being used indicated, "Policy: I provide the Resident and/or the Resident' transfer to a hospita Resident's facility b be "held." Note: A c given to the Residen | a.m., Regional Clinical ded an undated document, and indicated it was the policy if by the facility. The policy it is the policy of the facility to it, Resident's family member is legal representativeprior to ilinformation regarding the ed status and how the bed will copy of the Bed Hold policy it, Resident's family member gal representative will be int's record" | | 95% compliance at the end of months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthl QAPI meeting. Any concerns have been addressed. However, any patterns will be identified, needed Action Plan will be written Action Plan will be monitored by the Administrator weekly until resolved. | e oring y will ver, Any itten |
| | 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26) | | | | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii) Care Plan Timing | | | | |
| | failed to ensure care | and record review, the facility plan meetings had been ly manner for 2 of 24 residents | F 0657 | F657 Care plan timing/revisio It is the policy of this facility to ensure care plan meetings ha been conducted in a timely |) |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223 NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 ID PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG reviewed for care plan meetings (Residents 44 and 76). Findings include: ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG reviewed for care plan meetings (Residents 44 and 76). I. During an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. I. During an interview, on 10/2/24 at 2:31 p.m., Resident 44's record was reviewed on 10/7/24 at 10/44/2024 and resident 76 on 10/14/2024 and resident 76 on 10/14/2024 and resident 76 on 10/15/24. Resident 44's record was reviewed on 10/7/24 at 10/44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by winted that down and because of the body. | STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------|--|----------------------------------|-------|----------------------------|---|--------|------------------|--|
| NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION reviewed for care plan meetings (Residents 44 and 76). Toluring an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. Resident 44's record was reviewed on 10/7/24 at 10:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED | |
| WATERS OF COVINGTON, THE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: 1. During an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. Resident 44's record was reviewed on 10/7/24 at 10:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by 10. AUMATERS OF COVINGTON, IN 47932 ID PREFIX TAG PROVIDERS PLANOF CORRECTION (AS) COMPLETION PREFIX TAG PROVIDERS PLANOF CORRECTION (AS) (AS) COMPLETION DATE TAG PROVIDERS PLANOF CORRECTION (EACH CORRECTIO | | | 155223 | B. WI | NG | | 10/09/ | 2024 | |
| WATERS OF COVINGTON, THE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: 1. During an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. Resident 44's record was reviewed on 10/7/24 at 10:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by 10. AUMATERS OF COVINGTON, IN 47932 ID PREFIX TAG PROVIDERS PLANOF CORRECTION (AS) COMPLETION PREFIX TAG PROVIDERS PLANOF CORRECTION (AS) (AS) COMPLETION DATE TAG PROVIDERS PLANOF CORRECTION (EACH CORRECTIO | | | <u>I</u> | 1 | STREET | ADDRESS CITY STATE 710 COD | | | |
| WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG reviewed for care plan meetings (Residents 44 and 76). Findings include: 1. During an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. Resident 44's record was reviewed on 10/7/24 at 10:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by COVINGTON, IN 47932 ID PROVIDERS PLAN OF CORRECTION (CX5) COMPLETION DATE ID PROVIDERS PLAN OF CORRECTION (CX5) COMPLETION DATE 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A care plan meeting was completed for Resident 44 on 10/14/2024 and resident 76 on 10/15/24. 2. 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? | NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | | | | |
| (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION reviewed for care plan meetings (Residents 44 and 76). In the prefix of the precipitation of | WATERS | S OF COVINGTON | THE | | | | | | |
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| diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by the same deficient practice will be identified and what corrective action(s) will be taken? | | | | | | | | | |
| multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by be identified and what corrective action(s) will be taken? | | _ | | | 1 | - | | | |
| [a condition where the body's immune system attacks healthy cells, tissues, or organs by corrective action(s) will be taken? | | | | | | - | vill | | |
| attacks healthy cells, tissues, or organs by taken? | | | | | | | | | |
| | | _ | | | | | | | |
| | | _ | | | | | | | |
| | | | - | | | The SSD/Designee completed | | | |
| which protects nerve cells in the brain and spinal care plan meeting for residents 44 | | _ | - | | | _ | is 44 | | |
| cord) and adult failure to thrive (when an older on 10/14/2024 and 76 on | | · · | • | | | | | | |
| adult has a loss of appetite, eats and drinks less 10/15/2024 | | | | | | | . | | |
| than usual, loses weight, and is less active than normal). The SSD/Designee completed an audit of care plan meetings. | | | eight, and is less active than | | | - | an | | |
| | | normar). | | | | | | | |
| Those residents identified during A quarterly Minimum Data Set (MDS) the audit will have a care plan | | A guartarly Minim | um Data Sat (MDS) | | | | ٠ ١ | | |
| A quarterly Minimum Data Set (MDS) the audit will have a care plan assessment, dated 7/29/24, indicated the resident meeting scheduled by the | | | | | | • · · · · · · · · · · · · · · · · · · · | | | |
| had moderate cognitive deficit. SSD/Designee and will be | | | | | | , | | | |
| completed by 11/19/2024. | | nad moderate cogin | tirve deficit. | | | | | | |
| A care plan meeting progress note, dated 2/9/24 at 3. What measures will be put | | Δ care plan meeting | g progress note, dated 2/9/24 at | | | | . | | |
| 3:00 p.m., indicated a care plan meeting had been into place and what systemic | | | | | | · · | | | |
| held. The resident and her representative had changes will be made to | | | | | | 1 | · | | |
| been invited to attend the meeting and the ensure that the deficient | | | - | | | _ | | | |
| resident had attended the meeting. practice does not recur? | | | | | | | | | |
| The ADM/Designee in-serviced | | | <i>0</i> · | | | 1 - | ed | | |
| The record lacked documentation that a care plan the IDT on the care plan meeting | | The record lacked d | locumentation that a care plan | | | _ | | | |
| meeting had been held since 2/9/24. meeting had been held since 2/9/24. process for resident's quarterly ad | | | - | | | 1 · · · · · · · · · · · · · · · · · · · | - | | |
| as needed on 11/14/2024. | | meeting had been held since 2/9/24. | | | | 1 . | , | | |
| During an interview, on 10/7/24 at 12:10 p.m., the Additionally, any staff member | | During an interview | v, on 10/7/24 at 12:10 p.m., the | | | | r | | |
| Social Services Director (SSD) indicated she had that fails to comply with the points | | _ | - | | | | | | |
| not been in her position very long. She was not of this in-service will be further | | | | | | 1 | | | |
| aware that the resident had not had a meeting education and/or disciplined as | | _ | | | | | | | |
| since 2/9/24. When she became aware, she indicated. | | | | | | - | | | |

| STATEMEN | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | | X3) DATE SURVEY | |
|----------|--|--|------|--|--|-----------|-----------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPLETED | | |
| | | 155223 | B. W | ING | | 10/09/ | 2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | LISC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE | |
| | | For 8/7/24 and sent invitations | | | 4. How the corrective action(| · ′ I | | |
| | - | sident. Neither indicated they d the meeting. Because the | | | will be monitored to ensure t deficient practice will not | ne | | |
| | | did not plan to attend, the | | | recur, i.e. what quality | | | |
| | - | en held. She was not aware | | | assurance program will be p | ut | | |
| | that she should have documented that the meeting was not held and the explanation of why the resident had not attended, nor that a meeting | | | | into place? | | | |
| | | | | | The SSD/Designee will audit 1 | 10 | | |
| | | | | | residents weekly for care plan | | | |
| | could have been held without the resident and/or | | | | meetings weekly x 4 weeks, th | | | |
| | her representative p | resent. | | | 5 random residents weekly x 4 | 1 | | |
| | | | | | weeks, then 3 random residen | | | |
| | 2. During an interview, on 10/3/24 at 10:07 a.m., | | | | monthly x 4 months. If the faci | - | | |
| | Resident 76 indicated she could not recall when | | | | is within 95% compliance at th | | | |
| | • | meeting. Her daughter may | | | end of 6 months, the monitoring | - | | |
| | _ | but she had not told her about | | | will be stopped. Results of the | | | |
| | it. | | | | monitoring will be reviewed at | tne | | |
| | Resident 76's record | d was reviewed on 10/7/24 at | | | monthly QAPI meeting. Any concerns will have been | | | |
| | | file indicated the resident's | | | addressed. However, any patt | arne | | |
| | | but were not limited to, | | | will be identified. Any needed | Cirio | | |
| | - | nfarction (a serious condition | | | Action Plan will be written by t | he | | |
| | - | ood flow to the brain is | | | QAPI committee. Any written | | | |
| | blocked, causing br | ain tissue to die), Bell's palsy | | | Action Plan will be monitored | by | | |
| | (a neurological diso | order that causes temporary | | | the Administrator weekly until | | | |
| | | sis of the muscles on one side | | | resolved. | | | |
| | · · · · · · · · · · · · · · · · · · · | gnitive communication deficit | | | | | | |
| | , | ommunication caused by a | | | | | | |
| | disruption in cognit | ive processes). | | | | | | |
| | A | Data Sat (MDS) | | | | | | |
| | A quarterly Minimu | * * | | | | | | |
| | had no cognitive de | /27/24, indicated the resident | | | | | | |
| | nau no cognitive de | Hon. | | | | | | |
| | A care plan meeting | g progress note, dated 6/26/24 | | | | | | |
| | | ted a care plan meeting had | | | | | | |
| | _ | dent and her daughter had | | | | | | |
| | | meeting. The resident declined | | | | | | |
| | | nughter was present for the | | | | | | |
| | meeting. | - | | | | | | |
| | | | | | | | | |

| STATEMEN | EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|---|----------------------------------|--------|----------------------------|--|-----------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | | |
| | | 155223 | B. W | ING | | 10/09/ | 2024 | |
| | | <u> </u> | - | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF P | ROVIDER OR SUPPLIER | ł. | | 1600 E | | | | |
| WATERS | OF COVINGTON, | THE | | COVINGTON, IN 47932 | | | | |
| | | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCY) | | DATE | |
| | | locumentation that a care plan | | | | | | |
| | meeting had been he | eld since 6/26/24. | | | | | | |
| | D ' ' ' | 10/7/24 + 12 10 + 4 | | | | | | |
| | | 7, on 10/7/24 at 12:10 p.m., the | | | | | | |
| | | ector (SSD) indicated she had | | | | | | |
| | not been in her position very long. She was not aware that the resident had not had a meeting since 6/26/24. When she became aware, she | | | | | | | |
| | | | | | | | | |
| | | For 9/13/24 and sent invitations | | | | | | |
| | - | sident. She had not yet heard | | | | | | |
| | - | ent or the resident's family | | | | | | |
| | | attend. She was not aware | | | | | | |
| | _ | ument the reason why a | | | | | | |
| | | attend the meetings. She was | | | | | | |
| | | meeting could take place, | | | | | | |
| | | nd/or their representative | | | | | | |
| | declined to attend. | 1 | | | | | | |
| | | | | | | | | |
| | On 10/7/24 at 12:49 | p.m., the Director of Nursing | | | | | | |
| | (DON) provided a d | document, with a revised date | | | | | | |
| | of 9/18/18, titled, "I | Baseline Care Plan | | | | | | |
| | Assessment/Compre | ehensive Care Plans, " and | | | | | | |
| | indicated it was the | policy currently being used | | | | | | |
| | by the facility. The | policy indicated, "Procedure: | | | | | | |
| | - | cial Service Director or | | | | | | |
| | | the resident's responsible | | | | | | |
| | partyof the schedu | - | | | | | | |
| | conferenceThese | | | | | | | |
| | | erence8Anote will be | | | | | | |
| | | o the meeting to include all | | | | | | |
| | who attended" | | | | | | | |
| | 2.1.25(.)(2)(6) | | | | | | | |
| | 3.1-35(c)(2)(C) | | | | | | | |
| | 3.1-35(e) | | | | | | | |
| F 0690 | 483.25(e)(1)-(3) | | | | | | | |
| SS=D | , , , , , , | continence, Catheter, UTI | | | | | | |
| Bldg. 00 | Dowch Diaducti IIIC | onunction, Gauteter, OTT | | | | | | |
| 2.4g. 00 | | | F 00 | 590 | F690 Bowel/Bladder Incontine | nce | 11/19/2024 | |
| | Based on observation | on, record review, and | 1.00 | 070 | Catheter, UTI | 1100, | 11/17/2024 | |
| | | ,, wild | 1 | | | | | |

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

Event ID:

MNLH11 Facility ID: 000128

If continuation sheet Page 8 of 32

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------|--|----------------------------------|-------------------------------|------------|---|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155223 | B. WI | ING | | 10/09/2024 | |
| NAME OF F | | | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | C | | | LIBERTY ST | | |
| WATERS | OF COVINGTON, | THE | | COVIN | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | _ | TAG | DEFICIENCY) | DATE | |
| | l ' | ty failed to ensure a resident's | | | It is the policy of this facility to | | |
| | | catheter bag (a bag that | | | ensure a residents indwelling | | |
| | | a catheter inserted into the | | | urinary catheter bag is kept fro | | |
| | | rom coming in contact with the | | | coming in contact with the floo | or | |
| | floor for a resident with a UTI (urinary tract infection) for 1 of 4 residents reviewed for | | | | and accurately documenting | | |
| | | | | | urinary output. | (-) | |
| | · · | 4), and failed to ensure | | | 1 What corrective action(| | |
| | measured urine output amounts from indwelling urinary catheter bags were accurate for 2 of 4 | | | | will be accomplished for tho | | |
| | | | | | residents found to have been | n | |
| | | for catheter/UTI (Residents 4 | | | affected by the deficient | | |
| | and 1). | | | | practice? | | |
| | Findings include: | | | | Resident 4 catheter was | | |
| | 8 | | | | immediately removed from the | | |
| | 1. Resident 4's reco | rd was reviewed on 10/4/24 at | | | floor on 10/4/2024, by the | | |
| | | file indicated the resident's | | | DON/Designee. Resident 4 a | nd | |
| | _ | , but were not limited to, | | | resident 1 were assessed by | | |
| | _ | ux uropathy (a disorder of the | | | Nurse on 10/10/2024 with no | | |
| | | curs due to obstructed urinary | | | adverse effects noted. | | |
| | | her structural or functional) | | | | | |
| | and benign prostation | c hyperplasia (a | | | 2 How other residents | | |
| | non-cancerous cond | lition that causes the prostate | | | having the potential to be | | |
| | gland to enlarge, wl | hich can lead to urinary | | | affected by the same deficien | nt | |
| | issues). | | | | practice will be identified and | d | |
| | | | | | what corrective action(s) will | 1 | |
| | A quarterly Minimu | | | | be taken? | | |
| | assessment, dated 8 | /24/24, indicated the resident | | | | | |
| | had an indwelling c | atheter. | | | The DON/Designee complete | ed an | |
| | | | | | audit of catheters on 10/7/202 | 4. | |
| | _ | 3/26/24, indicated the resident | | | Those residents identified duri | ing | |
| | _ | obstructive uropathy and had | | | the audit will have orders revie | ewed | |
| | _ | ry catheter and had a goal that | | | for the need to have measured | d | |
| | _ | ience any signs or symptoms | | | output and catheters maintain | ed | |
| | | entions included, but were not | | | off the floor. | | |
| | limited to, documer | nt urine output every shift. | | | | | |
| | | | | | 3 What measures will be | | |
| | | d the resident had a current | | | put into place and what | | |
| | | a physician's order for an | systemic changes will be made | | | nde | |
| | antibiotic to treat th | e infection. | | | to ensure that the deficient | | |
| l | l | | | | practice does not recur? | I | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------|--|---|----------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155223 | B. WI | ING | | 10/09/ | /2024 |
| | | 1 | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | LIBERTY ST | | |
| \\/\\TEDG | OF COVINGTON, | THE | | | GTON, IN 47932 | | |
| VVATERS | OF COVINGTON, | 11112 | | COVINC | G I OIN, IIN 47 332 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | , dated 10/1/24, indicated to | | | | | |
| | | 60 milligram (mg) tablet of | | | The DON/Designee in-service | | |
| | · · | otic medication), by mouth two | | | staff on the Catheter policy on | | |
| | = | lays (stop date of 10/11/24) for | | | 11/14/2024 to include monitor | - | |
| | UTI. | | | | output accurately and maintain | - | |
| | | | | | bag off floor and providing priv | - | |
| | _ | oservation, on 10/4/24 at 3:01 | | | Additionally, any staff member | | |
| | _ | as laying in his bed sleeping. | | | that fails to comply with the po | oints | |
| | | ge bag was lying flat on the | | | of this in-service will further | | |
| | | the dignity bag (a bag that | | | education and/or disciplined a | S | |
| | | drainage bag so it's not | | | indicated. | | |
| | · • | d open exposing the sides of | | | | | |
| | the catheter drainage bag. The catheter drainage | | | | 4 How the corrective | | |
| | bag was directly in | contact with the floor. | | | action(s) will be monitored to | | |
| | D | | | | ensure the deficient practice | | |
| | _ | or, on 10/8/24 at 3:01 p.m., the Consultant 17 indicated it was | | | will not recur, i.e. what qualit | - | |
| | _ | he facility that catheter tubing | | | assurance program will be p | ut | |
| | _ | nage bags should never be in | | | into place? | | |
| | | or. It would be an infection | | | The DON/designee will audit | | |
| | control risk. | or, it would be an infection | | | residents with catheters for | | |
| | control risk. | | | | positioning and measured out | nut 5 | |
| | On 10/8/24 at 2:47 | p.m., Regional Clinical | | | times a week x 4 weeks, then | | |
| | · · | ided an undated document, | | | times a week x 4 weeks, then | O | |
| | • | and indicated it was the policy | | | weekly x 4 months. If the facili | tv is | |
| | | d by the facility. The policy | | | within 95% compliance at the | - | |
| | indicated, "Proced | | | | of 6 months, the monitoring wi | | |
| | | adhere to professional | | | stopped. Results of the monitor | | |
| | - | e and facility policy and | | | will be reviewed at the monthly | _ | |
| | - | erence to infection prevention | | | QAPI meeting. Any concerns | - | |
| | and control techniq | • | | | have been addressed. Howev | | |
| | • | | | | any patterns will be identified. | • | |
| | 2. Resident 4's reco | rd was reviewed on 10/4/24 at | | | needed Action Plan will be wri | • | |
| | 11:18 a.m. The prof | file indicated the resident's | | | by the QAPI committee. Any | | |
| | - | , but were not limited to, | | | written Action Plan will be | | |
| | obstructive and refl | ux uropathy (a disorder of the | | | monitored by the Administrato | r | |
| | urinary tract that oc | curs due to obstructed urinary | | | weekly until resolved. | | |
| | · · | ner structural or functional) | | | - | | |
| | and benign prostation | c hyperplasia (a | | | | | |
| | | lition that causes the prostate | l | | | | |

| STATEMEN | ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | SURVEY |
|-----------|--|---|-------|----------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPLETED | |
| | | 155223 | B. WI | NG | | 10/09 | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | LIBERTY ST | | |
| WATERS | OF COVINGTON, | THE | | | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 1 - | hich can lead to urinary | | | | | |
| | issues). | | | | | | |
| | A 1 34''' | D + C + (MDC) | | | | | |
| | | um Data Set (MDS) | | | | | |
| | had an indwelling c | 8/24/24, indicated the resident | | | | | |
| | | catheter. | | | | | |
| | A care plan, dated 8/26/24, indicated the resident | | | | | | |
| | | obstructive uropathy and had | | | | | |
| | _ | ry catheter and had a goal that | | | | | |
| | _ | ience any signs or symptoms | | | | | |
| | of infection. Interventions included, but were not | | | | | | |
| | limited to, documer | nt urine output every shift. | | | | | |
| | | | | | | | |
| | | , dated 8/19/24, indicated to | | | | | |
| | l ~ | re every shift, ensure catheter | | | | | |
| | | upper thigh and ensure | | | | | |
| | 1 | ag is below the waist and | | | | | |
| | covered. | | | | | | |
| | A physician's order | , dated 8/21/24, indicated to | | | | | |
| | | (size of a catheter using the | | | | | |
| | | Coude (a catheter with a curved | | | | | |
| | | s through tight spots in the | | | | | |
| | | bladder neck) catheter with a | | | | | |
| | | r (cc) bulb (portion of the | | | | | |
| | | iflated to hold the catheter in | | | | | |
| | place) due to obstru | active uropathy. | | | | | |
| | | | | | | | |
| | _ | ember and October 2024 | | | | | |
| | | stration Records (TARs) | | | | | |
| | | umentation and the resident's | | | | | |
| | | re (POC) task document, dated | | | | | |
| | _ | 4/24, completed by the Certified | | | | | |
| | _ | (CNAs), indicated significant | | | | | |
| | | e output amounts that had The discrepancies were as | | | | | |
| | followed: | The discrepancies were as | | | | | |
| | ionowed. | | | | | | |
| | a. 9/5/24. the POC | form indicated an output value | | | | | |
| | , , | mareare an output farae | | | | | |

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

Event ID:

MNLH11 Facility ID: 000128

If continuation sheet Page 11 of 32

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223 | | (X2) MULTIPLE CC A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--|---|---|-----------------|---|-------|
| | PROVIDER OR SUPPLIER | | 1600 E | ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | RIATE |
| TAG | | R LSC IDENTIFYING INFORMATION rs), and the TAR indicated 700 ml of 50 ml. | TAG | DEFICIENCE | DATE |
| | of 2300 ml, and the discrepancy of 500 c. 9/7/24, the POC of 1250 ml, and the discrepancy of 400 c. 9/8/24, the POC of 1250 ml, and the discrepancy of 400 c. 9/8/24, the POC of 1250 ml, and the discrepancy of 400 c. 9/8/24, the POC of 1250 ml, and the discrepancy of 400 c. 9/8/24, the POC of 1250 ml, and the discrepancy of 400 ml, and the discrepancy of 400 ml, and the discrepancy of 500 ml, and the discrepancy of 400 ml, and the | form indicated an output value TAR indicated 850 ml with a ml. form indicated an output value | | | |
| | discrepancy of 100 | | | | |
| | | form indicated an output value TAR indicated 1250 ml with a ml. | | | |
| | | Form indicated an output value ΓAR indicated 450 ml with a ml. | | | |
| | | form indicated an output value TAR indicated 1000 ml with a ml. | | | |
| | | Form indicated an output value ΓAR indicated 1000 ml with a nl. | | | |
| | | C form indicated an output value TAR indicated 750 ml with a 0 ml. | | | |
| | | form indicated an output value TAR indicated 1200 ml with a ml. | | | |
| | j. 9/15/24: the POC | form indicated an output value | | | |

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Event ID:

MNLH11 Facility ID: 000128

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| STATEMEN | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE | SURVEY |
|-----------|--|--------------------------------|----------------------------|----------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155223 | B. W | ING | | 10/09/2024 | |
| | | | | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | LIBERTY ST | | |
| \\/\\TEDS | OF COVINGTON, | THE | | | GTON, IN 47932 | | |
| WATERC | or covingion, | | | COVINC | 910N, IN 41932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | · | TAR indicated 1300 ml with a | | | | | |
| | discrepancy of 600 | ml. | | | | | |
| | | | | | | | |
| | | form indicated an output value | | | | | |
| | of 1000 ml, and the TAR indicated 750 ml with a discrepancy of 250 ml. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | form indicated an output value | | | | | |
| | of 800 ml, and the TAR indicated 1725 ml with a | | | | | | |
| | discrepancy of 925 | ml. | | | | | |
| | 0/10/04 /1 PO | | | | | | |
| | m. 9/18/24: the POC form indicated an output | | | | | | |
| | value of 1800 ml, and the TAR indicated 1000 ml | | | | | | |
| | with a discrepancy | of 800 ml. | | | | | |
| | 0/10/24. the DOC | form indicated an output value | | | | | |
| | | TAR indicated 600 ml with a | | | | | |
| | discrepancy of 875 | | | | | | |
| | discrepancy of 873 | mi. | | | | | |
| | o 9/20/24: the POC | form indicated an output value | | | | | |
| | | FAR indicated 1100 ml with a | | | | | |
| | discrepancy of 400 | | | | | | |
| | discrepancy of 400 | 1111. | | | | | |
| | p. 9/2.1/24: the POC | form indicated an output value | | | | | |
| | - | TAR indicated 1450 ml with a | | | | | |
| | discrepancy of 350 | | | | | | |
| | ansoropanies or see | | | | | | |
| | a. 9/22/24: the POC | form indicated an output value | | | | | |
| | _ | ΓAR indicated 850 ml with no | | | | | |
| | discrepancy noted. | | | | | | |
| | , , , | | | | | | |
| | r. 9/23/24: the POC | form indicated an output value | | | | | |
| | | TAR indicated 650 ml with a | | | | | |
| | discrepancy of 400 | | | | | | |
| | | | | | | | |
| | s. 9/24/24: the POC | form indicated an output value | | | | | |
| | | ΓAR indicated 1000 ml with a | | | | | |
| | discrepancy of 150 | | | | | | |
| | | | | | | | |
| | t. 9/25/24: the POC | form indicated an output value | | | | | |

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Event ID:

MNLH11 Facility ID: 000128

If continuation sheet Page 13 of 32

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | ì í | ILDING | nstruction 00 | (X3) DATE : COMPL 10/09/ | ETED |
|--------------------------|--|--|-----|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | | 1600 E | DDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | TAR indicated 800 ml with a | | 0 | | | 5.112 |
| | | C form indicated an output value ΓAR indicated 1000 ml with a ml. | | | | | |
| | | C form indicated an output value ΓAR indicated 650 ml with a nl. | | | | | |
| | | C form indicated an output nd the TAR indicated 1000 ml y noted. | | | | | |
| | | C form indicated an output value FAR indicated 450 ml with a ml. | | | | | |
| | - | C form indicated an output value ΓAR indicated 450 ml with a nl. | | | | | |
| | | C form indicated an output value TAR indicated 1450 ml with no | | | | | |
| | | C form indicated an output d the TAR indicated 1000 ml of 100 ml. | | | | | |
| | | C form indicated an output nd the TAR indicated 600 ml of 1350 ml. | | | | | |
| | value of 900 ml, an documentation of a resulting in a discre | C form indicated an output d the TAR lacked ny output measurement, epancy of 900 ml. 3. Resident ewed on 10/4/24 at 10:19 a.m. | | | | | |

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Event ID:

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| | VT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION 00 | COMI | E SURVEY PLETED 9/2024 |
|--------------------------|--|---|-------------------------------------|--|----------|------------------------------|
| | PROVIDER OR SUPPLIER | | 1600 E | FADDRESS, CITY, STATE, ZIP C E LIBERTY ST NGTON, IN 47932 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | included, but were a of urinary tract infe any part of the urinary treflux uropathy (co kidneys and urinary flow), and neuromu (condition that occu muscles of the blad properly with the brissues). A quarterly Minimu assessment, dated 7 had severe cognitivi indwelling catheter inserted into the bla ostomy (a surgical popening in the abdoleave the body). A care plan, dated 6 had frequent urinary Interventions includes taff would monitor abnormal findings to the constructive reflux urinary a bag outside of the obstructive reflux urincluded, but were and output every shany changes, and pushift and as needed. A physician order, a catheter 16 Fr (Fremerican) and a property of the control of the catheter 16 Fr (Fremerican) and a property of the catheter 16 Fr (Fremerican) and a property of the catheter 16 Fr (Fremerican) and a property of the catheter 16 Fr (Fremerican) and a property of the catheter 16 Fr (Fremerican) and a property of the urinary of the catheter 16 Fr (Fremerican) and the urinary of the urinary o | /15/24, indicated the resident e impairment and had an (a thin hollow tube that is idder to drain urine) and procedure that creates an aminal wall to allow waste to (5/10/23, indicated the resident by tract infections. Ided, but were not limited to, residents' vitals and report to the doctor. (5/26/20, indicated the resident rotomy tube (a thin flexible the directly from the kidney into body) and a catheter due to ropathy. Interventions not limited to, monitor intake ift, notify medical doctor of rovide catheter care every | | | | |

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Event ID:

 $\begin{array}{lll} MNLH11 & {\it Facility ID:} & 000128 \end{array}$

If continuation sheet

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--------------------------|---|---|--|--|---------------------------------------|--|
| | ROVIDER OR SUPPLIER | | 1600 E | ADDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | |
| TAU | needed for occlusio | n and every night shift and ending the 14th every | TAU | | DATE | |
| | catheter care every anchored to the upp | dated 9/21/24, indicated shift, ensure catheter is er thigh and ensure catheter elow the waist and covered y catheter. | | | | |
| | 1 had several holes outputs had not bee other documentation (POC) task form that | ord (TAR) indicated Resident where catheter care and n documented. There was n noted on a Point of Care at was completed by the ssistants (CNA) that catheter | | | | |
| | and the September 2 | September 2024 POC task form 2024 TAR, the following cies in urinary output values | | | | |
| | | form indicated an output value rs), and the TAR indicated repancy of 150ml. | | | | |
| | | form indicated an output value TAR indicated 1400ml with a l. | | | | |
| | | orm indicated an output value TAR indicated 1900ml with a nl. | | | | |
| | | form indicated an output value TAR indicated 1900ml with a ml. | | | | |

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Event ID:

MNLH11 Facility ID: 000128

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------------|--|----------------------------------|--------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. Bl | JILDING | 00 | COMPL | ETED |
| | | 155223 | B. W | ING | | 10/09/ | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | | LIBERTY ST | | |
| WATERS | OF COVINGTON, | THE | | | GTON, IN 47932 | | |
| VV/ (L () | | | | 000 | 31011, 114 47 302 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | form indicated an output value | | | | | |
| | · · · · · · · · · · · · · · · · · · · | TAR indicated 1400 with a | | | | | |
| | discrepancy of 50m | ıl. | | | | | |
| | C 0/10/24 4 POC | C . 1. 4 1 . 4 4 1 | | | | | |
| | | form indicated an output value | | | | | |
| | of 2350ml, and the TAR indicated 900ml with a discrepancy of 1450ml. | | | | | | |
| | discrepancy of 1430 | OIIII. | | | | | |
| | g. 9/11/24 the POC | form indicated an output value | | | | | |
| | _ | TAR indicated 1300 with a | | | | | |
| | discrepancy of 550 | | | | | | |
| | 1 3 | | | | | | |
| | h. 9/12/24 the POC | form indicated an output value | | | | | |
| | of 900ml, and the TAR indicated 1600ml with a discrepancy of 700ml. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | i. 9/13/24 the POC | form indicated an output value | | | | | |
| | of 1500ml, and the | TAR indicated 1940ml with a | | | | | |
| | discrepancy of 4401 | ml. | | | | | |
| | | | | | | | |
| | 1 · | form indicated an output value | | | | | |
| | · · | TAR indicated 1100ml with a | | | | | |
| | discrepancy of 1150 | UmI. | | | | | |
| | lr 0/15/24 the DOC | form indicated an output value | | | | | |
| | | TAR indicated 800ml with a | | | | | |
| | discrepancy of 450 | | | | | | |
| | discrepancy of 4301 | | | | | | |
| | 1. 9/16/24 the POC | form indicated an output value | | | | | |
| | | TAR indicated 1550ml with a | | | | | |
| | discrepancy of 550 | | | | | | |
| | | | | | | | |
| | m. 9/17/24 the POC | C form indicated an output value | | | | | |
| | | TAR indicated 1400ml with a | | | | | |
| | discrepancy of 150 | | | | | | |
| | | | | | | | |
| | n. 9/18/24 the POC | form indicated an output value | | | | | |
| | of 1650ml, and the | TAR indicated 820ml with a | | | | | |
| | discrepancy of 830a | ml. | | | | | |
| | | | | | | | |
| | I | | - 1 | | | | I |

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Event ID:

MNLH11 Facility ID: 000128

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--------------------------|------------------------------------|---|------|--|---|---------------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | | | 1600 E | NDDRESS, CITY, STATE, ZIP COD LIBERTY ST GTON, IN 47932 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | form indicated an output value TAR indicated 450ml with a ml. | | | | | |
| | - | form indicated an output value R indicated 2600ml with a 0ml. | | | | | |
| | | form indicated an output value TAR indicated 2500 with a ml. | | | | | |
| | | form indicated an output value TAR indicated 1650ml with a ml. | | | | | |
| | | form indicated an output value TAR indicated 800ml with a ml. | | | | | |
| | | form indicated an output value faR indicated 1250ml with a ml. | | | | | |
| | | form indicated an output value TAR indicated 950ml with a ml. | | | | | |
| | | form indicated an output value TAR indicated 1700ml with a l. | | | | | |
| | | TAR indicated an output value TAR indicated 2200ml with a ml. | | | | | |
| | | form indicated an output value TAR indicated 3150ml with a 0ml. | | | | | |

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Event ID:

MNLH11 Facility ID: 000128

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|----------------------------------|--------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155223 | B. W | ING | | 10/09/ | /2024 |
| | | | | CTREET | DDDEGG CITY CTATE TIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| \A/A TED | OF COMMOTON | THE | | | LIBERTY ST | | |
| WATERS | S OF COVINGTON, | IHE | | COVING | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | - | DATE |
| | y. 9/29/24 the POC | form indicated an output value | | | | | |
| | of 2400ml, and the | TAR indicated 800ml with a | | | | | |
| | discrepancy of 1600 | Oml. | | | | | |
| | | | | | | | |
| | z. 9/30/24 the POC | form indicated an output value | | | | | |
| | of 2200ml, and the TAR indicated 2200ml, with | | | | | | |
| | output totals that ma | atched. | | | | | |
| | | | | | | | |
| | _ | y, on 10/4/24 at 3:00 p.m., the | | | | | |
| | _ | nsultant indicated the CNA's | | | | | |
| | | atheter drainage bags and then | | | | | |
| | | that information to the nurses. | | | | | |
| | There should not be two separate staff members | | | | | | |
| | | t because it could cause | | | | | |
| | discrepancies and c | ould impact residents' care. | | | | | |
| | | | | | | | |
| | _ | y, on 10/4/24 at 3:38 p.m., | | | | | |
| | | Nurse (LPN) 8 indicated she | | | | | |
| | | mes where to document the | | | | | |
| | _ | se it was placed in different | | | | | |
| | | er system. She indicated the | | | | | |
| | · · | ys report to her when they | | | | | |
| | | pags. She understood how | | | | | |
| | | repancies in the urine output | | | | | |
| | documentation. | | | | | | |
| | 0 10/7/24 + 0.20 | 4 D. (CN . | | | | | |
| | | a.m., the Director of Nursing | | | | | |
| | | locument and indicated it was | | | | | |
| | | klist and it was the expectation | | | | | |
| | residents who had c | asure urinary output on the | | | | | |
| | residents who had c | carneters. | | | | | |
| | On 10/4/24 at 2:20 | p.m., the Regional Nurse | | | | | |
| | | ed an undated document, titled, | | | | | |
| | _ | dicated it was the policy | | | | | |
| | | | | | | | |
| | currently being used by the facility. The policy indicated, "b) need for accurate measurement of | | | | | | |
| | | The resident will have ongoing | | | | | |
| | | atheter related to the potential | | | | | |
| | _ | - | | | | | |
| | of Offis and recogn | nizing, reporting, and | | | | | |

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

Event ID:

MNLH11 Facility ID: 000128

If continuation sheet Page 19 of 32

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--|---|---|--|--|--|---|----------------------------|
| | | 155223 | B. WI | | | 10/09/ | /2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| 1710 | addressing significa | | | 1710 | | | DATE |
| | 3.1-4(a)(1) | | | | | | |
| F 0693 SS=D Bldg. 00 | 483.25(g)(4)(5) Tube Feeding Mg | mt/Restore Eating Skills | | | | | |
| Bidg. 00 | review, the facility is bottle of tube feeding that contained all the delivered directly in intestines through a to eat normally by infor 1 of 1 resident resident 74). Findings include: On 10/04/24 at 10:4 tube feeding formult table. One full bottle than half of the continuicated they were CAL (a calorie densiblend of slowly digning Neither bottle was 1. During an interview Licensed Practical in had given Resident at about 8:30 a.m. the bolus out of the Glucerna that was lebedside table. She is who opened the bottle was 1. | on 10/04/24 at 10:43 a.m., Nurse (LPN) 8 indicated she 74 his bolus (syringe) feeding nat morning and had given him mostly empty bottle of ocated on the resident's ndicated she was not the one tle and was not sure who | F 06 | 593 | F693 Tube Feeding Mgmt/Res Eating Skills It is the policy of this facility to ensure tube feeding is dated a labeled. 1 What corrective action(will be accomplished for those residents found to have been affected by the deficient practice? Tube feeding formula was immediately removed from resident 74's room on 10/4/20 by the DON/Designee. 2 How other residents having the potential to be affected by the same deficien practice will be identified and what corrective action(s) will be taken? All residents receiving tube feedings have the potential to affected, therefore, this plan o correction applies to those residents. | and s) se 1 24 td | 11/19/2024 |
| | were opened, they were opened date, expirate | When tube feeding formulas were required to label it with an tion date, and initials. Once the ed, it was only good for 24 | | | 3 What measures will be put into place and what systemic changes will be ma to ensure that the deficient | ıde | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|---|---|----------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155223 | B. Wl | NG | | 10/09/ | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | | LIBERTY ST | | |
| \\/\\TED | C OF COVINCTON | TUE | | | GTON, IN 47932 | | |
| VVATERS | OF COVINGTON, | 11112 | | COVINC | J I OIN, IIN 47 332 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | as not sure when it was | | | practice does not recur? | | |
| | - | hing would have been for her | | | | | |
| | to discard it and get | a new one. | | | The DON/Designee in-service | ed | |
| | | | | | staff on Enteral Tube Feeding | to | |
| | | p.m., observed another bottle | | | include dating, add time open | ed | |
| | of Glucerna tube feed to be on Resident 74's | | | | and labeling a bottle when ope | ened | |
| | | container had a handwritten | | | via syringe on 11/14/2024. | | |
| | - | 24 and initials for LPN 8. The | | | Additionally, any staff member | | |
| | | nentation of the time it had | | | that fails to comply with the po | ints | |
| | been opened. | | | | of this in-service will further | | |
| | | | | | education and/or disciplined a | S | |
| | During an interview on 10/04/24 at 2:30 p.m., | | | | indicated. | | |
| | | of Glucerna located in | | | | | |
| | | on the bedside table with the | | | 4 How the corrective | | |
| | - | g (DON). She indicated that the | | | action(s) will be monitored to | | |
| | - | ned, and along with the date | | | ensure the deficient practice | | |
| | | tle should have a time opened | | | will not recur, i.e. what qualit | - | |
| | | e. Once opened, the formula | | | assurance program will be p | ut | |
| | was only good for 7 | 72 hours. | | | into place? | | |
| | On 10/04/24 at 2:25 | En m. Desident 741s record was | | | The DONI/designed will evolit 3 | F la . a | |
| | | 5 p.m., Resident 74's record was noses included, but were not | | | The DON/designee will audit | | |
| | _ | natic intracranial hemorrhage in | | | feeding formula for proper lab | - | |
| | | (bleeding in the brain that | | | for date and time opened 5 time | | |
| | _ | ma or surgery), dysphagia | | | a week x 4 weeks, then 3 time | | |
| | (difficulty swallowi | | | | week x 4 weeks, then weekly months. If the facility is within | A 4 | |
| | | d built up in the brain due to a | | | 95% compliance at the end of | 6 | |
| | * * | in's fluid passages, and | | | · · · · · · · · · · · · · · · · · · · | | |
| | aphasia (difficulty r | 1 0 1 | | | months, the monitoring will be stopped. Results of the monito | | |
| | | expressing oneself). | | | will be reviewed at the monthly | _ | |
| | anderstanding, and | expressing onesen). | | | QAPI meeting. Any concerns | - | |
| | A nhysician's order | , with a start date of 9/25/24, | | | have been addressed. Howev | | |
| | | ster an enteral feed (a way to | | | any patterns will be identified. | • | |
| | | | | | needed Action Plan will be wri | - | |
| | provide nutrition and fluids to someone unable to eat or drink) of Glucerna 1.2 at 285 milliliters (mL) | | | | by the QAPI committee. Any | | |
| | per g-tube (a small, flexible tube that was | | | | written Action Plan will be | | |
| | surgically inserted through the abdomen and into | | | | monitored by the Administrato | r | |
| | | ver food, liquids, and | | | weekly until resolved. | • | |
| | medication) every 4 | - | | | Wookiy unun 10301764. | | |
| | incurcation, every | i nouid. | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | COMPLET |) DATE SURVEY COMPLETED 10/09/2024 | |
|----------------------------|--|---|--|---|---------|--|--|
| | ROVIDER OR SUPPLIER OF COVINGTON, | | STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE (| (X5) COMPLETION DATE | |
| | A quarterly Minimum 10/01/23, indicated and had severe cognormal of the co | ım Data Set (MDS), dated Resident 74 had a feeding tube | | | | | |
| | shorter hand time is manufacturer, hand after initial connecti | specified by the set product for up to 48 hours ion when clean technique and e used. Otherwise hang for no | | | | | |
| F 0732 SS=A Bldg. 00 | review, the facility | on, interview, and record failed to ensure accurate posted daily for 1 of 6 days | F 0732 | F732 (D) Posted Nurse Staffing Information | 1 | 11/19/2024 | |

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Event ID:

MNLH11 Facility ID: 000128

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|---|-----------------------------------|-----------------------------------|------------------|--|-----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ЛLDING | 00 | COMPL | ETED |
| | | 155223 | B. W | ING | | 10/09/ | /2024 |
| | | | | _ | | | |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | LIBERTY ST | | |
| WATERS | OF COVINGTON, | THE | | COVING | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | It is the policy of the facility to | | |
| | Findings include: | | | | post the nurse staffing data da | aily | |
| | | | | | at the beginning of each shift. | | |
| | During an observat | ion, on 10/2/24 at 9:45 a.m., the | | | Data must be posted in a clea | r | |
| | staffing sheet poste | d on the inside wall by the | | | and readable format in a prom | inent | |
| | front door was date | d 9/30/24. | | | place readily accessible to | | |
| | | | | | residents and visitors. | | |
| | During an observat | ion, on 10/2/24 at 11:12 a.m., | | | | | |
| | the staffing sheet po | osted on the inside wall by the | | | 1 What corrective action(s | s) | |
| | front door was date | d 9/30/24. | | | will be accomplished for thos | se | |
| | | | | | residents found to have beer | 1 | |
| | During an interview | v, on 10/3/24 at 9:36 a.m., the | | | affected by the deficient | | |
| | Director of Nursing | (DON) indicated the | | | practice? | | |
| | expectation was that | t the Assistant Director of | | | No residents were found to be | • | |
| | Nursing (ADON) w | ould post the staffing sheet | | | affected by the deficient practi | ce. | |
| | daily. She indicated | the staffing sheet should be | | | | | |
| | accurate with the co | orrect date and staffing | | | 2 How other residents | | |
| | information. | | | | having the potential to be | | |
| | | | | | affected by the same deficien | nt | |
| | _ | v, on 10/9/24 at 1:18 p.m., the | | | practice will be identified and | d | |
| | | ated it was the responsibility | | | what corrective action(s) will | l | |
| | | st the staffing sheet daily. She | | | be taken? | | |
| | | N had worked the night before | | | Residents who reside in the | | |
| | | son had forgotten to post the | facility have the potential to be | | | | |
| | staffing sheet for 10 | 0/1/24 as well. | | | affected by this deficient pract | ice. | |
| | 0 10/2/24 : 0.22 | d DOM 11.1 | | | | _ | |
| | | a.m., the DON provided an | | | 3 What measures will be p | | |
| | | titled, "Staffing Posting | | | into place and what systemic | | |
| | - | indicated it was the policy | | | changes will be made to | | |
| | | d by the facility. The policy | | | ensure that the deficient | | |
| | · · | he policy of the facility, in | | | practice does not recur? | | |
| | - | ledicare/Medicaid Services, | | | The Administrator /Designee | | |
| | | requirement of daily posting of | | | in-serviced the Director of Nur | sing | |
| | _ | facility1) SNFs (skilled | | | and scheduler on the policy | | |
| | nursing facilities) and NFs (nursing facilities) must post daily, at the beginning of each shift, the | | | | "Guidelines for BIPA Staffing | | |
| | | | | | Posting Requirement" on | - 4 - CC | |
| | | ft schedule for the 24 hour | | | 11/14/2024. Additionally, any | | |
| | | equired posted data includes: a) | | | member that fails to comply w | | |
| | • | urrent Date c) Current Census | | | the points of this in-service wil | | |
| 1 | " | | 1 | | further educated and/or discip | iined | I |

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

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/09/2024 | | | |
|----------------------------|---|--|--|---|--|--|--|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | | | | as indicated. 5 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be pinto place? The Administrator/Director of Nursing/Designee will audit the BIPA staffing posting and loca 5 times a week x 4 weeks, then once a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliant at the end of the 6 months; the monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, an patterns will be identified. Any needed Action Plan will be wriby the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved. | y ut e tion n 3 e ce ce en ve y tten | | | |
| F 0758 SS=D Bldg. 00 | 483.45(c)(3)(e)(1) Free from Unnec I Use | -(5) Psychotropic Meds/PRN | | | | | | |
| | failed to address a p 1 of 5 residents revi medications (Reside Findings include: On 10/04/24 Reside His diagnoses inclu | harmacy recommendation for ewed for unnecessary ent 36). ent 36's record was reviewed. ded, but were not limited to, (a period of time when | F 0758 | F758 Free from Unnec Psychotropic meds/PRN use It is the policy of this facility to addressed pharmacy recommendations for unneces medications. 1 What corrective action(will be accomplished for thos residents found to have beer affected by the deficient | s) se | | | |

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Event ID:

MNLH11 Facility ID: 000128

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| CTATEMENT OF DEFICIENCIES VANDOUDED/CUDDI IED/CLIA VAND | | VALLETINE CONCERNICATION | | I | | | | |
|---|-----------------------|----------------------------------|-------|----------------------------|--|-----------|------------------|--|
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. Bl | UILDING | 00 | COMPLETED | | |
| | | 155223 | B. W | ING _ | | 10/09 | /2024 | |
| | | l . | | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | | |
| NAME OF P | ROVIDER OR SUPPLIEF | ₹ | | | LIBERTY ST | | | |
| \\\\\ TED6 | | TUE | | | | | | |
| VVATERS | OF COVINGTON, | I П С | | COVING | GTON, IN 47932 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΔTE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | someone experienc | es a depressed mood, along | | | practice? | | | |
| | with other sympton | ns, that lasts for at least two | | | | | | |
| | weeks), insomnia (a | a sleep disorder that makes it | | | DON/Designee assessed resi | dent | | |
| | | stay asleep, or get good quality | | | 36 on 10/10/2024 and no neg | | | |
| | _ | mmunication deficit (struggle | | | outcomes. Resident to contin | | | |
| | | e skills, paying attention when | | | on medication. | | | |
| | | g spoken to, reasoning and | | | | | | |
| | | and short and long-term | | | The Physician/Designee asse | essed | | |
| | | ation (a mental state where | | | and documented reason dose | | | |
| | | used about their time, place, or | | | reduction not indicated on | • | | |
| | | nallucinations (the experience | | | 11/7/2024. | | | |
| | • • | or voices that were not actually | | | 11/1/2024. | | | |
| | _ | _ | | | 2 How other residents | | | |
| there), and visual hallucinations (a perceptual experience where a person sees things that were | | | | | | | | |
| | - | person sees things that were | | | having the potential to be | 4 | | |
| | not there). | | | | affected by the same deficie | | | |
| | | 1 1 1 (20) | | | practice will be identified an | | | |
| | | an's order, dated 6/29/23, | | | what corrective action(s) wil | I | | |
| | | ster Zoloft (sertraline) 50 | | | be taken? | | | |
| | milligrams (mg) da | ily for depression. | | | | | | |
| | | | | | The DON/Designee complete | | | |
| | | ım Data Set (MDS) | | | 90 day look back of pharmacy | / | | |
| | | 0/01/23, indicated the resident | | | recommendations and any | | | |
| | was cognitively into | act. | | | documentation follow up was | | | |
| | | | | | addressed by 11/14/2024 | | | |
| | On 10/08/24 at 1:08 | | | | | | | |
| | | or Resident 36 were reviewed. | | | 3 What measures will be | | | |
| | | from Pharmacy Management | | | put into place and what | | | |
| | · | /23/23, indicated the order for | | | systemic changes will be ma | ade | | |
| | Zoloft (sertraline) 5 | 0 mg daily was due for a review | | | to ensure that the deficient | | | |
| | and dose reduction | attempt. The recommendation | | | practice does not recur? | | | |
| | requested to decrea | se Zoloft (sertraline) to 25 mg | | | | | | |
| | daily, and for the p | provider to document current | | | The ADM/Designee in-servic | ed | | |
| | mental and behavio | or status, review the new dose | | | the DON and SSD on pharma | | | |
| | recommendation, o | r provide detailed reasons that | | | recommendations to include | = | | |
| | | as not indicated. The | | | physician documentation for | | | |
| | | cked documentation of a | | | reason dose reduction was no | ot | | |
| | response from the p | | | | indicated on 11/14/2024. | | | |
| | | | | | | | | |
| | During an interview | v on 10/08/24 at 3:02 p.m., the | | | 4 How the corrective | | | |
| | _ | g (DON) indicated the pharmacy | | | action(s) will be monitored t | 0 | | |
| | | | | | | | | |

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

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

| review had not been addressed. She was not an employee at the facility during the time the pharmacy review should have been addressed and was not sure why it had not been completed. During an interview on 10/08/24 at 3:16 p.m., the Regional Nurse Consultant (RNC) 18 indicated she did not know what happened or why the pharmacy recommendation was not addressed and was not able to find any additional documentation in the electronic record to indicate that it was addressed by the provider. On 10/08/24 at 3:20 p.m., the RNC 18 provided an undated document, titled, "Distribution of Medication Regimen Review Report" and indicated it was the policy currently being used by the facility. The policy indicated, "The consultant pharmacist will report any recommendations of apparent irregularities resulting from the medication regimen review of each resident to the attending physician, the director of nursing and medical director on a medication regimen review report form or in electronic record keeping system. Each recommendation must be acted upon1. The report form will be used by the consultant pharmacist will retain the information. 3. The report will be forwarded to the director of nursing. 4. The attending physician and/or | | MENT OF DEFICIENCIES AN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--|--------|---|--|------|--|--|---|------------|
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGISTRATE APPROPRIATE DATE RESCREDED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE RESCREDED TO THE APPROPRIATE DATE RESCREDED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE TO THE APPROPRIATE TO THE APPROPRIATE TO THE APPROPRIATE DATE TO THE APPROPRIATE TO | | | | | 1600 E | LIBERTY ST | | |
| employee at the facility during the time the pharmacy review should have been addressed and was not sure why it had not been completed. During an interview on 10/08/24 at 3:16 p.m., the Regional Nurse Consultant (RNC) 18 indicated she did not know what happened or why the pharmacy recommendation was not addressed and was not able to find any additional documentation in the electronic record to indicate that it was addressed by the provider. On 10/08/24 at 3:20 p.m., the RNC 18 provided an undated document, titled, "Distribution of Medication Regimen Review Report" and indicated it was the policy currently being used by the facility. The policy indicated, "The consultant pharmacist will report any recommendations of apparent irregularities resulting from the medication regimen review of each resident to the attending physician, the director of nursing and medical director on a medication regimen review report form or in electronic record keeping system. Each recommendation must be acted upon1. The report form will be used by the consultant pharmacists twill retain the information. 3. The report will be forwarded to the director of nursing. 4. The attending physician and/or | PREFIX | (EACH DEFICIEN REGULATORY OI | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION |
| Regional Nurse Consultant (RNC) 18 indicated she did not know what happened or why the pharmacy recommendation was not addressed and was not able to find any additional documentation in the electronic record to indicate that it was addressed by the provider. On 10/08/24 at 3:20 p.m., the RNC 18 provided an undated document, titled, "Distribution of Medication Regimen Review Report" and indicated it was the policy currently being used by the facility. The policy indicated, "The consultant pharmacist will report any recommendations of apparent irregularities resident to the attending physician, the director of nursing and medical director on a medication regimen review report form or in electronic record keeping system. Each recommendation must be acted upon1. The consultant pharmaceist to communicate findings of monthly pharmaceutical care consultation. 2. The consultant pharmacist will retain the information. 3. The report will be forwarded to the director of nursing. 4. The attending physician and/or | | employee at the fac pharmacy review sl | ility during the time the nould have been addressed | | | will not recur, i.e. what qualit assurance program will be p | :y | |
| response to the recommendations made by the consultant pharmacist directly on the medication regimen review report form or in the resident's medical record. If physician disagrees with recommendation or no change is being made, the physician must document rationale in the resident's medical record. 5. The director of | | Regional Nurse Coshe did not know with pharmacy recommendation in that it was addressed. On 10/08/24 at 3:20 undated document, Medication Regimendicated it was the by the facility. The consultant pharmacy recommendations or resulting from the reach resident to the director of nursing medication regimentelectronic record keeps recommendation may be pharmacist to compart form will be pharmacy at the pharmacy of the recommendation of the recommendation will be pharmacy at the medical director will be nursing. 4. The atternedical director will be recommendation of the | nsultant (RNC) 18 indicated that happened or why the endation was not addressed find any additional ne electronic record to indicate d by the provider. O p.m., the RNC 18 provided an titled, "Distribution of an Review Report" and policy currently being used policy indicated, "The ist will report any of apparent irregularities medication regimen review of attending physician, the and medical director on a neview report form or in the propersion of the end by the consultant municate findings of monthly the consultation. 2. The ist will retain the information. The interpolation is the provided to the director of minding physician and/or and the provided to the director of minding physician and/or and the provided to the medication ort form or in the resident's obsystician disagrees with the condange is being made, the ument rationale in the | | | pharmacy recommendations monthly x 6 months for recommendations being review by physician, documentation for reason dose reduction not indicated and follow up completed the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitor will be reviewed at the monthly QAPI meeting. Any concerns thave been addressed. However any patterns will be identified. In needed Action Plan will be written Action Plan will be monitored by the Administratory. | or eted. oring y will er, Any tten | |

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Event ID:

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If continuation sheet

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155223 | | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/09/2024 | |
|--|---|--|---------------------|---|--------------------------|
| | PROVIDER OR SUPPLIER | | 1600 E | ADDRESS, CITY, STATE, ZIP COD E LIBERTY ST NGTON, IN 47932 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| F 0812 SS=D Bldg. 00 | nursing will follow needed relative to the Physician response in changes in medicing resident will be forwed documented in election and the nurse will opharmacy" 3.1-48(b)(2) 483.60(i)(1)(2) Food Procurement, Store Based on observation failed to ensure expended failed to ensure facing restraints, and failed hazardous food (undeseparately from othe 2 of 2 kitchen observation failed to ensure facing from the cook 12 preparing in not covered by a harmonic covered by a harmonic food for the thawing beef identified as thawing resting on top edge thawing meats, was | up with any nursing actions he physician's response. 6. to recommendations resulting ation therapy for individual warded to the POS or tronic record keeping system refer the medication from the representation from the repr | F 0812 | F812 Food Procurement It is the policy of this facility to ensure expired foods are disp of facial hair is covered and uncooked meats are stored separately from other foods. 1 What corrective action will be accomplished for tho residents found to have bee affected by the deficient practice? The DON/Designee assessed residents on 10/10/2024 and residents were affected by the cited practice. 2 How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken? | 11/19/2024 osed (s) se n |
| | During an interview on 10/02/24 at 10:25 a.m., the DM indicated that cooked and raw meat should | | | The Dietary Manager/Designer audited all pantries for expired food items and disposed as | |

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

Event ID:

MNLH11

Facility ID: 000128

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/09/2024 155223 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON, THE COVINGTON, IN 47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE not be on the same shelf. needed on 11/1/2024, staff was educated on use of hair restraints On 10/02/24 at 10:31 a.m., observed the front hall including beards on 11/14/2024 pantry to have a loaf of bread dated 9/16/24. The and staff educated on thawing DM indicated once the bread was opened and foods on 11/14/2024. dated, it was only good for 7 days and should have been discarded. What measures will be put into place and what On 10/02/24 at 10:36 a.m., observed the middle hall systemic changes will be made pantry to have a loaf of bread dated 9/11/24. She to ensure that the deficient indicated that the night dietary aides were practice does not recur? responsible for monitoring the pantry expiration dates daily. Dietary Manager/Designee in-serviced the dietary department On 10/02/24 at 10:39 a.m., entered the back hall on disposing of expired foods, use pantry with the DM, she took a loaf of opened of hair restraints including beards bread from the counter and disposed of it in the and thawing frozen foods on trash. When asked why she threw it away, she 11/14/2024. Additionally, any staff indicated it should have been discarded and that member that fails to comply with it was dated for 9/11/24. the points of this in-service will be further educated and/or disciplined During an interview on 10/02/24 at 11:37 a.m., the as indicated. DM indicated that pork and beef should not have been thawing together on the same tray. How the corrective action(s) will be monitored to On 10/07/24 at 12:25 p.m., observed Cook 12 in the ensure the deficient practice food preparation area with a mustache that was will not recur, i.e. what quality not covered by a hair restraint. assurance program will be put into place? During an interview on 10/07/24 at 12:44 p.m., the DM indicated everyone who had facial hair was The Dietary Manager/Designee supposed to have it covered with a hair restraint will audit pantries for expired foods or they would have shave. If staff had a mustache, and audit frozen food placement it was also required to be covered. When asked if during thawing 5 times a week x 4 Cook 12's mustache was covered, she turned weeks, then 3 times a week x 4 around and advised Cook 12 to pull the hair weeks, then once a week x 4 restraint up to cover his mustache. When she months for foods that are properly turned back around, she indicated that his sealed, labeled and dated. The mustache was not covered. Dietary Manager will audit 10 random staff members a week x 4

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|---|-----------------------------------|----------------------------|------------------------------------|--|------------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. Bl | A. BUILDING <u>00</u> | | COMPLETED | | |
| 155223 | | B. W | B. WING | | | 10/09/2024 | |
| | | | | CTREET | ADDRESS SITE STATE SID COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | LIBERTY ST | | |
| WATERS | S OF COVINGTON | , IHE | | COVIN | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | DATE |
| | On 10/2/24 at 11:4 | 8 a.m., the DM provided an | | | weeks, then 5 random staff | | |
| | undated document | titled, "Date Marking," and | | | members a week x 4 weeks th | ien | |
| | | e policy currently being used | | | 3 random staff members a mo | | |
| | | policy indicated, "Once a | | x 4 months for hair coverings | | | |
| | 1 . | it will be re-dated with the date | | being worn during food preparation | | ation | |
| | | ed and shall be used by the safe | | | and serving. If the facility is w | | |
| | _ | lines4. Food items should be | | | 95% compliance at the end of | | |
| | | ne food item doesn't have a | | | months, the monitoring will be | | |
| | | rer expiration date and has | | stopped. Results of the monitoring | | | |
| | | | | | will be reviewed at the monthly | ~ | |
| | been refrigerated for 7 days" | | | QAPI meeting. Any concerns will | | · | |
| | On 10/2/24 at 11:4 | 8 a.m., the DM provided an | | | have been addressed. Howev | | |
| | undated document titled, "Food Storage," and | | | | any patterns will be identified. | | |
| | indicated it was the policy currently being used | | | | needed Action Plan will be wri | · · | |
| | | policy indicated, "store raw | | | by the QAPI committee. Any | | |
| | | fish separately from cooked | | | written Action Plan will be | | |
| | and ready-to-eat fo | | | | monitored by the Administrato | r | |
| | una ready to eat to | | | | weekly until resolved. | ' | |
| | On 10/7/24 at 2:20 | p.m., the DM provided an | | | weekly until reserved. | | |
| | | titled, "Code of Dress and | | | | | |
| | Personal Appearance," and indicated it was the | | | | | | |
| | policy currently being used by the facility. The | | | | | | |
| | policy indicated, "1. The following practices | | | | | | |
| | and guidelines will be enforced by the Dining | | | | | | |
| | Services Manager. A. Hairnets, hair restraints, and | | | | | | |
| | beard guards shall | | | | | | |
| | ocara gaaras shan | oc wom | | | | | |
| | 3.1-21(i)(3) | | | | | | |
| | 3.1-21(1)(3) | | | | | | |
| F 9999 | | | | | | | |
| | | | | | | | |
| Bldg. 00 | | | | | | | |
| .3. 00 | 3.1-14 PERSONNI | EL | F 9 | 999 | F9999 Personal | | 11/19/2024 |
| | _ | an organized ongoing in-service | | ,,, | It is the policy of this facility to | | 11/17/2027 |
| | | ing program planned in | | | provide annual in-serving for s | staff. | |
| | advance for all pers | | | | 1 What corrective action(| | |
| | _ | de, but not be limited to, the | | | will be accomplished for thos | | |
| | following: | , | | | residents found to have been | | |
| | (1) Residents' right | s. | | | affected by the deficient | - | |
| | | control of infection. | | | practice? | | |
| I | | control of infection. | 1 | | Practice: | | |

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Event ID:

MNLH11 Facility ID: 000128

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| STATEMENT OF DEFICIENCIES X1) | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|-------------------------------|---|-----------------------------------|-----------------------|---|--|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | COMPLETED | | |
| 155223 | | 155223 | B. WING | | | 10/09/2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | LIBERTY ST | | |
| \\/\TED | S OF COVINGTON | TUE | | | GTON, IN 47932 | | |
| WATER | 3 OF COVINGTON, | , 1116 | | COVIIN | G10N, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | .TE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | DATE |
| | (3) Fire prevention | | | | | | |
| | (4) Safety and accid | - | | | No residents were identified to be affected by the cited deficiency. | | |
| | | llized populations served. | | | | | |
| | | vely impaired residents. | | | | | |
| | (l) The frequency and content of in-service | | | | 2 How other residents | | |
| | | ing programs shall be in | | | having the potential to be | | |
| | accordance with the | | | | affected by the same deficien | | |
| | _ | acility personnel as follows. For | | | practice will be identified and | d | |
| | | this shall include at least | | what corrective action(s | | | |
| | twelve (12) hours of | - | | | be taken? | | |
| | calendar year and six (6) hours of in-service per | | | | | | |
| | calendar year for nonnursing personnel. | | | | The BOM/HR/Designee with | | |
| | (m) Inservice programs for items required under | | | complete an audit of employee | | е | |
| | subsection (k) shall contain a means to assess | | | files for completion of annual | | | |
| | learning by participants. | | | education by 11/7/2024. | | | |
| | (n) The administrator may approve attendance at | | | | Education to be completed by | | |
| | outside workshops and continuing education | | | | 11/14/2024 to include LPN 20 | | |
| | programs related to that | | | | CNA 26, CNA 27, Housekeep | ing | |
| | individual's responsibilities in the facility. | | | | aide 28 and RN 29. | | |
| | Documented attendance at these workshops and | | | | | | |
| | programs meets the requirements for | | | | 3 What measures will be | | |
| | in-service training. | | | put into place and what | | | |
| | (o) Inservice records shall be maintained and shall | | | | systemic changes will be ma | ide | |
| | indicate the following: | | | | to ensure that the deficient | | |
| | (1) The time, date, and location. | | | | practice does not recur? | | |
| | (2) The name of the instructor. | | | | The Device of News Consolla | 4 | |
| | (3) The title of the instructor. | | | | The Regional Nurse Consultant | | |
| | (4) The names of the participants. | | | | in-serviced the DON/ADM on | | |
| | (5) The program content of in-service. | | | | annual in-services required for staff | | |
| | The employee will acknowledge attendance by | | | on 11/14/2024. Additionally, a staff member that fails to com | | - | |
| | written signature. | | | | with the points of this in-service | | |
| | This state rule is not met as evidenced by: | | | | with the points of this in-service will be further educated and/or | | |
| | This state rule is not met as evidenced by: | | | disciplined as indicated. | | | |
| | Based on record review and interview the facility failed to ensure employees were provided annual | | | | alsolphilieu as illulcateu. | | |
| | | | | | 4 How the corrective | | |
| | in-service training for 5 of 10 employees' files | | | | | | |
| | reviewed. | 101 5 of 10 employees files | | action(s) will be monitored to | | | |
| | 10 viewed. | | | | ensure the deficient practice will not recur, i.e. what qualit | | |
| | Findings include: | | | | assurance program will be p | - | |
| | i mamga menade. | | 1 | | assurance program win be p | ut | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|--|-----------------------------------|----------------------------|------------------------------|---|------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | COMPLETED | | |
| | | 155223 | B. WING | | 10/09/2024 | | |
| | | | | CEDEET | ADDRESS OF A STATE OF COD | | |
| NAME OF F | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | LIBERTY ST | | |
| WATERS | S OF COVINGTON, | THE | | COVING | GTON, IN 47932 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROVIDED'S DI AN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE |
| | | | | | into place? | | |
| | During the review of | of state form 5440 titled, | | | | | |
| | _ | s," on 10/9/24 at 10:30 a.m., the | | The BOM/HR will audit 10 rai | | dom | |
| | following was noted | | | | employee and new employee files | | |
| | l reme wing was note. | | | | weekly x 4 weeks, then 5 rand | | |
| | a Licensed Practica | al Nurse (LPN) 20 employee | | | employee and new employee | | |
| | | . The file indicated LPN 20 | | | weekly x 4 weeks then 5 rando | | |
| | | training for abuse, resident | | | employees and new employee | | |
| | | a in January 2023, but lacked | | | monthly x 4 months for comple | | |
| | | employee had resident rights | | | annual in-services If the faci | | |
| | | | | | is within 95% compliance at the | • | |
| | or dementia training in 2024. His hire date was 1/2/23. | | | | end of 6 months, the monitoring | | |
| | 1/2/23. | | | | will be stopped. Results of the | _ | |
| | h Cartified Nursels | Assistant (CNA) 26 amployee | | | T = | | |
| | b. Certified Nurse's Assistant (CNA) 26 employee files were reviewed. The filed indicated CNA 26 | | | | monitoring will be reviewed at the monthly QAPI meeting. Any | | |
| | | | | | concerns will have been | | |
| | received in-service training for abuse, resident | | | | addressed. However, any patterns | | |
| | rights, and dementia in August 2023, but lacked | | | | | erns | |
| | documentation the employee had received the | | | | will be identified. Any needed | | |
| | training in 2024. Her hire date was 8/9/23. | | | | Action Plan will be written by t | ne | |
| | | | | | QAPI committee. Any written | | |
| | c. CNA 27 employee files were reviewed. The filed | | | | Action Plan will be monitored I | ру | |
| | indicated CNA 27 received in-service training for | | | | the Administrator weekly until | | |
| | abuse, resident rights, and dementia in July 2023, | | | | resolved. | | |
| | but lacked documentation the employee had | | | | | | |
| | received resident rights or dementia training in | | | | | | |
| | 2024. Her hire date was 7/31/23. | | | | | | |
| | | | | | | | |
| | | de 28 employee files were | | | | | |
| | | ndicated housekeeping aide 28 | | | | | |
| | received in-service | training for abuse, resident | | | | | |
| | rights, and dementia | a in May 2022, but lacked | | | | | |
| | documentation the | employee had received | | | | | |
| resident rights and dementia training in 2024. His | | | | | | | |
| | hire date was 5/10/22. | | | | | | |
| | | | | | | | |
| | e. Registered Nurse (RN) 29 employee files were | | | | | | |
| | reviewed. The filed | indicated RN 29 received | | | | | |
| | in-service training for abuse, resident rights and | | | | | | |
| | dementia in August | | | | | | |
| documentation the employee had received | | | | | | | |

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Event ID:

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

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155223 | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/09/2024 | | |
|---|---|---|--|---|--|---------------------------------------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE | | | STREET ADDRESS, CITY, STATE, ZIP COD 1600 E LIBERTY ST COVINGTON, IN 47932 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP TAG DEFICIENCY) | | | (X5) COMPLETION DATE | |
| | resident rights and dementia training in 2024. Her hire date was 8/9/23. During an interview, on 10/9/14 at 11:55 a.m., the Regional Director of Operations indicated the facility was aware there was an issue with the annual in-services being completed and they are working on a resolution. She indicated they were unable to provide documentation that the 3-hour annual dementia training had been completed or resident rights. During an interview, on 10/9/24 at 1:15 p.m., the Regional Director of Operations indicated they do not have a policy regarding employee in-services, but they followed the state regulation. | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MNLH11 Facility ID: 000128 If continuation sheet Page 32 of 32