STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440676, IN00440661, IN00440698, IN00441674, and IN00441804. Complaint IN00441804 - Federal/state deficiencies related to the allegations are cited at F807. Complaint IN00441674 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00440676 - Federal/state deficiencies related to the allegations are cited at F695. Complaint IN00440661 - Federal/state deficiencies related to the allegations are cited at F9999. Complaint IN00440698 - Federal/state deficiencies related to the allegations are cited at F9999. Survey dates: August 29, 30, and September 3, 2024 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 7 Medicaid: 38 Other: 36 Total: 81 These deficiencies reflect State Findings cited in	F 0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections sat forth on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa	Foreman	09/27/2024

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on September 13, 2024.			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation and interview, the facility failed to ensure respiratory equipment was cleaned, dated, and stored appropriately and residents had respiratory treatment orders for 8 of 8 Residents reviewed for respiratory care (Residents C, D, E, F, G, H, J, and K). Findings include: On 8/29/24 at 9:45 a.m., during initial observation of the facility. The following was observed. Resident J's oxygen was being administered at 2 L (liters) per nasal cannula (NC) (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels). The oxygen tubing was dated 5/29/24. There was no dated oxygen equipment storage bag in the room. On 8/29/24 at 9:46 a.m., Resident K's, oxygen was being administered at 2 L per NC. There was no date on the oxygen tubing. An empty humidity bottle was attached to the oxygen delivery concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen. It converts ambient room air to a higher concentration of level of oxygen) was dated 2/7/24. There was no dated oxygen equipment storage bag in the room. On 8/29/24 at 9:47 a.m., Resident H's oxygen was being administered at 3 L per NC. The oxygen equipment storage bag was dated 4/2/24. The	F 0695	F695 – Respiratory/Tracheostomy Care and Suctioning It is the policy of this facility to ensure respiratory equipment is cleaned, dated and stored appropriately and residents have orders for respiratory treatment. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed residents C, D, E, F, G , H, J and K for oxygen use. Orders for oxygen administration obtained as needed. Oxygen tubing, nebulizer tubing, storage bags, and humidification bottles were changed and dated on or before 9/24/24 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; DON/ designee completed audit on 9/19/24 for residents with respiratory equipment to ensure it was dated and stored in a plastic bag. DON/Designee completed audit on 9/24/24 to ensure that residents with oxygen have orders.	09/25/2024

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	nebulizer treatment administration set was unbagged and sitting on top of nebulizer machine (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece). On 8/29/24 at 9:49 a.m., Resident C had an undated oxygen equipment storage bag lying on the oxygen concentrator. Nebulizer equipment (typically consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) was stored in an undated bag. The oxygen tubing was not dated. On 8/29/24 at 9:50 a.m., Resident D had oxygen tubing unbagged and lying on the floor. The medical record indicated there was no order for oxygen administration. On 8/29/24 at 9:52a.m., Resident E had undated oxygen tubing lying on the floor unbagged. The nebulizer equipment was lying on the bedside table. There was no dated oxygen equipment storage bag in the room. On 8/29/24 at 9:53 a.m., Resident F had oxygen being administered continually by NC. The humidity water bottle (a refillable bottle that adds moisture to oxygen to prevent the upper airway from drying out) was dated 8/29/24. There was no date on the oxygen tubing. There was no dated oxygen equipment storage bag in the room. The medical record indicated there was no order for oxygen administration. On 8/29/24 at 9:55 a.m., Resident G had an oxygen equipment storage bag dated 8/21/24. The nebulizer equipment storage bag was dated 8/7/24.		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/ designee educated nursing staff on or before 9/19/24 regarding facility policy and procedure on respiratory orders, dating equipment and storage. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur; Respiratory audit will be completed by the DON/Designee 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	

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	The medical record indicated there was no order for oxygen administration. On 8/30/24 at 1:20 p.m., during general observation Resident E's nebulizer treatment equipment was not bagged. There was no dated nebulizer equipment storage bag in the room. On 8/30/24 at 1:26 p.m., during an interview Qualified Medication Aide (QMA) 6 acknowledge all the oxygen tubing and nebulizer equipment should be dated and bagged. The employee indicated all oxygen equipment was changed weekly. On 8/30/24 at 1:55 p.m., during an interview with the Assistant Director of Nursing (ADON) she indicated oxygen tubing was changed weekly. She indicated the staff dated all tubing, the storage bag, and water bottles when they were changed. She indicated the nebulizer treatment and oxygen equipment must be in a dated bag when not in use. On 8/30/2024 at 3:18 p.m., the Regional Nurse Consultant provided an undated document titled, "Oxygen Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...4. Tubing, humidifier bottles and filters will be changed, cleaned and maintained no less than weekly and PRN. Each will be labeled with date, time and initialed by staff completing this service to equipment ...." This citation relates to Complaint IN00440676. 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview the facility failed to obtain ordered medication for administration for 1 of 3 residents reviewed for medication administration (Resident AA). Findings include: On 8/30/24 at 5:00 p.m., the medical record of Resident AA was reviewed. The resident was admitted to the facility on 2/6/23. Diagnosis included, but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar is too high), hypertension (high blood pressure), and congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Physician orders included, but were not limited to, Sitagliptin-metformin HCL (Janumet) 50-500 mg (milligram) 1 tablet two times daily for diabetes. A Minimum Data Set (MDS) assessment, dated 8/8/24, indicated the resident was cognitively intact. A care plan, dated 2/6/23, indicated the resident was at risk for hypoglycemia (low blood sugar) and or hyperglycemia (high blood sugar) related to diagnosis of diabetes mellitus. Interventions included, but were not limited to, administer medications as ordered by Medical Doctor (MD), dated 2/6/2023. The Medication Administration Record (MAR) for June indicated on 6/29/24 and 6/30/24 the resident	F 0755	F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records It is the policy of this facility to ensure ordered medications are obtained for administration. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident AA's medication was audited by the DON/Designee and medication had been delivered on 8/22/24. The DON/Designee assessed resident AA and no negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; The DON/Designee completed an audit of ordered medications and medications were obtained for administration on 9/20/24. will be made to ensure that the deficient practice does not recur; DON/ designee educated nursing staff on or before 9/19/24 regarding facility policy and procedure on Medication ordering and administration. Additionally, any staff member that fails to	09/25/2024

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	did not receive metformin HCL two times per day as ordered. The medical record lacked documentation of physician notification of missed dose. The MAR for July indicated on 7/1/24 and 7/2/24 the resident did not receive metformin HCL two times per day as ordered. On 7/3/24 the medication was not administered for the morning dose. The medical record lacked documentation of physician notification of missed doses. On 8/29/24 at 5:10 p.m., during an interview Licensed Practical Nurse (LPN) 11 indicated if a medication was not available, they would obtain it from the emergency drug Cubex machine (a smart cabinet and software system that helps manage pharmacy supplies and controlled substances). If it were not available there, they would order the medication from the backup pharmacy. On 9/3/24 at 9:30 a.m., during an interview Registered Nurse (RN) 10 indicated if a medication was not available, they would obtain it from the emergency drug kit (EDK). If it was not available in the EDK, they would order it from the pharmacy. If a dose was missed, they would notify the physician or the nurse practitioner. On 9/3/24 at 10:00 a.m., during an interview the Director of Nursing (DON) indicated if a medication was not available, they would look in the EDK. If it was not there, they would call pharmacy for an immediate delivery. They were to notify the physician of the missed dose of medication. On 9/3/2024 at 10:12 a.m., the provided an undated document titled, "Unavailable Medications Medication Shortages," and indicated it was the		comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur; Medication availability audit will be completed on 20 random residents weekly x 4 weeks, then 10 random residents weekly x 4 weeks, then 10 random residents monthly x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	

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	policy currently being used by the facility. The policy indicated, "...Policy ...medication shortage during normal pharmacy hours ...1. Facility nurse will call the pharmacy to determine the status of the order. If the medication has not been ordered, facility nurse will place the order/reorder for the next scheduled delivery. 2. If the next available delivery causes a delay or a missed dose, the nurse should obtain medication from the emergency medication supply. 3. If the medication is not available in emergency medication supply, the facility nurse should notify the pharmacy and attempt to arrange for an emergency delivery. 4. If the next scheduled dose has been missed the nurse will notify the physician of the missed dosed of medication ...." This citation relates to Complaint IN00441674. 3.1-25(a)			
F 0807 SS=E Bldg. 00	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration Based on observation, interview, and record review, the facility failed to ensure residents had alternative hydration choices available for 2 of 3 days of the survey. This had the potential to effect for 81 of 81 residents who received hydration from the kitchen. Finding includes: On 8/29/24 at 12:50 p.m., Certified Nursing Aide (CNA) 20 indicated the Dietary Manager (DM) had told the staff on the units that staff were no longer able to make the residents coffee on the units, because it needed to be temped prior to	F 0807	F807 – Drinks Avail to Meet Needs/Prefs/Hydration It is the intent of this facility to ensure residents have alternative hydration choices available. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Residents were assessed by the DON/Designee on 9/24/24, no negative outcomes related to alleged deficient practice. How other residents having the potential to be affected by the	09/25/2024

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	serving coffee to the residents. The residents liked to have coffee when they got up in the mornings and the kitchen did not serve drinks until 7 a.m. with the breakfast. The Dietary Director removed the coffee grounds from the units and indicated staff were not allowed to make coffee for the residents. The residents were really upset about not having the coffee. One of the residents wanted coffee earlier today and the Dietary Director told the resident no, because it was too close to coffee hour. Coffee hour began at 10 a.m. Staff passed out ice water every shift, but not coffee nor any other drinks. The units used to make coffee for the residents all the time and the residents could get it any time they wanted it. During an observation of the units' pantries, on 8/29/24, no drinks were observed in the refrigerators and the pantries did not have coffee supplies. During an interview with the DM, on 8/29/24 at 4:03 p.m., she indicated residents were served drinks and coffee, when the kitchen opened at 7 a.m. The Director of Nursing (DON) had taken the coffee out of the units' pantries due to the coffee not being temped. The DM indicated she had purchased individual containers of orange juice for the pantries to have available for residents, but the dietary staff had served the orange juice to the residents during the breakfast meals in the dining room. On 8/30/24 at 3:25 p.m., the Regional Nurse Consultant (RN) 22 provided and identified an undated document as a current facility policy, titled "Policy and Procedure Hydration Management." The policy indicated, "...Purpose: To establish guidelines to ensure each resident		same deficient practice will be identified and what corrective actions will be taken; All residents have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary Manager/designee educated dietary staff on 9/19/2024 on availability of fluids. The DON/Designee educated nursing staff on availability of fluids on 9/19/2024 Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur; Fluid availability audit will be completed by the Dietary Manager/Designee 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If	

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	receives sufficient fluid intake to maintain proper hydration in accordance with calculated needs...Policy: It is the policy of the facility to monitor the resident's fluid balance in accordance with assessed need or problems...1. The Dietary Manager or Registered Dietician (RD) will calculate fluid requirements for each resident admitted to the facility and will record fluid needs in the Nutritional Assessment...4. If not restricted, fluids will be offered at bedside and at the nurses' station...6. Fluids will be offered mid-morning, mid-afternoon, and at bedtime, in addition to mealtime and during medication administration...7. Staff will encourage fluid consumption during in room and other resident contacts unless contraindicated...." This citation relates to Complaint IN00441804. 3.1-46(b)		necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	
F 9999 Bldg. 00	3.1-13 ADMINISTRATON AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:	F 9999	F9999 Administration and Management It is the intent of the facility to report to the Indiana Department of Health an outbreak of an unknown rash. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Residents K, L, M , N, O, P, Q, R, S, T, U, V and W were assessed and did not have a negative outcome. How other residents having	09/25/2024

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	(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This state rule was not met as evidenced by: Based on record review and interview the facility failed to report to the Indiana Department of Health an outbreak of an unknown rash that affected 13 of 13 residents reviewed for skin rash (Residents K, L, M, N, O, P, Q, R, S, T, U, V, W). Findings include: On 8/29/24 at 10:30 a.m., observed Resident K lying in bed. The resident indicated she had a full body rash. She indicated the doctor said it was eczema. Observed a red rash covering her chest and all extremities. Observed some small white patchy areas on the left arm and left thigh area. She indicated she had a tub of cream in her bedside table for itching, but the staff had to apply it. She complained of constant intense itching. On 8/29/24 at 12:26 p.m., during an interview Certified Nurse Aide (CNA) 7 indicated the staff had been told some residents had a rash but there were no residents with a rash at the time. On 8/29/24 at 12:50 p.m., during interview CNA 8 indicated she had seen two residents with a rash last week, as soon as it was reported the residents were treated. On 8/29/24 at 2:58 p.m., during interview Housekeeper 9 indicated. She had not been informed of any residents with rash and no		the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; All residents have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/Administrator was educated on 9/19/24 by RDO and RNC on reporting of outbreaks. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur; RDO/RNC/Designee will complete an audit on reporting of outbreaks 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be	

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	employees had complained of a rash to her. On 8/29/24 at 4:05 p.m., during interview Registered Nurse (RN) 10 indicated there had been some residents with rashes and testing for scabies came back negative. She indicated she had heard of two CNAs who had complained of a rash. On 8/29/24 at 4:30 p.m., record review indicated beginning 8/10/24 a rash was identified on several residents. On 8/14/24, 13 residents were tested for scabies. All test results returned on 8/21/24 and indicated tests were negative. On 8/29/24 at 5:04 p.m., during a confidential interview Employee 11 indicated several residents had broken out in a severe rash a few weeks ago. Some were itching to the point they were bleeding. The employee indicated the physician ordered treatment and skin testing for scabies. The employee indicated the residents were treated with topical cream and afterwards they were tested for scabies. The employee indicated they were itching and had developed the same rash as the residents. When the employee was tested by their primary physician, they tested positive for scabies. The employee indicated another employee had been examined by a physician and had tested positive for scabies. On 8/29/24 at 5:49 p.m., during confidential interview Employee 4 indicated several residents had a severe rash and they developed the same rash. The employee was tested by their physician and diagnosed with scabies. On 8/29/24 at 5:58 p.m., during a confidential interview Employee 5 indicated a few weeks ago several residents had developed a severe rash.		written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

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	The residents were scratching with hairbrushes due to severe itching. The rash was reported to the Director of Nurses (DON). The employee indicated the physicians did order treatments for scabies for several residents. On 8/30/24 at 12:15 p.m., during an interview with the Assistant Director of Nursing (ADON) she indicated she tested the residents for scabies according to directions from their lab. On 8/30/24 at 1:30 p.m., during interview the ADON indicated she was unsure if she tested the residents before or after topical treatment. She indicated they did place all affected residents in isolation and encouraged them to remain in their rooms. Many of the affected residents would not remain in room and had wandered around the facility. No additional testing had been completed. On 8/30/24 at 1:55 p.m., during an interview with the Regional Nurse Consultant she indicated the facility did not report an outbreak of an unknown rash at the time because they did not know if it was scabies. On 8/30/24 at 2:11 p.m., during phone interview with the interim Director of Nursing (DON) she indicated some staff informed her they were going to be tested for scabies but had not been informed of any positive scabies tests. She indicated she did not report a rash of 13 residents because she did not know for sure what the rash was. She acknowledged it was abnormal to have that many residents break out with various rashes, though the physicians did treat the rash with medications used to treat scabies. On 8/30/2024 at 3:18 p.m., the Regional Nurse Consultant provided an undated document, titled,			

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	"Policy and Procedure Suspicious Rashes," and indicated it was the policy currently being used by the facility. The policy indicated, "...12. Report to local and State health departments if facility determines active outbreak of confirmed communicable infection ...." The "Long-Term Care Abuse and Incident Policy#: IDOH-CSHR-LTC-002 Reporting Policy," found on the Indiana Department of Health Long Term Care/Nursing Homes website and signed by the Assistant Commissioner on 4/1/24, indicated skilled nursing homes were required to report the following: " ... 14. Unusual occurrence: An unusual occurrence includes, but is not limited to: a. epidemic outbreaks b. poisonings c. fires d. major accidents ... 4. Epidemic outbreaks a. Required to report at least three residents with the same infection in one defined area (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48-hour period; or 10% or more of the current building census with the same infection. b. Communicable disease reporting per current national and/or state standards and guidelines ...." This citation relates to Complaints IN00440661and IN00440698.			