STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	COMPLETED
		155053	B. WING		03/28/2024
			STRI	EET ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIE	R		E 11TH ST	
WATERS	OF RUSHVILLE	SKILLED NURSING FACILITY, THE		SHVILLE, IN 46173	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFI		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		DATE
F 0000					
Bldg. 00					
		Recertification and State	F 0000	="" p=""> Preparation and/or	
	_	This visit included a State		execution of this plan of correct	I
	Residential Licensi	ure Survey.		in general, or this corrective a	I
				in particular, does not constitu	I
	Survey dates: Marc	ch 25, 26, 27 & 28 2024		an admission of agreement by	this
		00010		facility of the facts alleged or	
	Facility number: 00			conclusions set forth in this	
	Provider number: 1			statement of deficiencies. The	
	AIM number: 1002	2/3930		plan of correction and specific	I
	G D 1 T			corrective actions are prepare	
	Census Bed Type:			and/or executed in compliance	9
	SNF/NF: 34			with State and Federal Law.	
	Residential: 12				
	Total: 46			The Facility's date of alleged compliance is 4/29/2024. The	
	Census Payor Type	e:		Facility is respectfully requesti	na
	Medicare: 3			paper compliance for all	
	Medicaid: 27			deficiencies in this POC.	
	Other: 4				
	Total: 34				
	These deficiencies	reflect State Findings cited in			
	accordance with 41	10 IAC 16.2-3.1.			
	Quality review con	npleted on April 4, 2024			
F 0641	483.20(g)				
SS=D	Accuracy of Asse	essments			
Bldg. 00	-	acy of Assessments.			
	,	must accurately reflect the			
	resident's status.	mast accuratory remote the			
	. 55,45,110 014140.		F 0641	F 641 Accuracy of Assessmer	nts: 04/29/2024
	Based on interview	and record review, the facility	1 00-1	It is the policy of this facility to	0 1/2//2027
		code Section J regarding falls		ensure accuracy of all	
		ts reviewed for Minimum Data		assessments.	
	*	ident 14 and Resident 16)		What corrective actions will be	,
	, ,	,		accomplished for those reside	
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Diana Gore Administrator 04/29/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 1 of 30

STATEMEN	T 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
		155053	B. WI	ING		03/28/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			1TH ST		
WATERS	OF RUSHVILLE S	KILLED NURSING FACILITY, THE			/ILLE, IN 46173		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Findings include:				found to have been affected b	v the	
	Ü				deficient practice?	,	
	1. The clinical recor	rd for Resident 14 was reviewed			Resident 14 & 16's fall		
	on 3/25/2024 at 2:4	5 p.m. The medical diagnosis			assessments were modified o	n	
	included dementia.				3/27/2024 by the MDS nurse \	with	
					no negative outcome related t		
	An Annual Minimu	m Data Set (MDS)			this alleged deficient practice.		
	Assessment, dated	1/27/2024, indicated Resident			How other residents having th		
	14 had one fall with	nout injury during that review			potential to be affected by the		
	period.				same deficient practice will be		
•				identified and what corrective			
A nursing progress note, dated 1/13/2024,				actions will be taken?			
indicated that Resident 14 was found lying on her				All residents have the potentia	ıl to		
		or mat with a bruise to the			be affected. All residents with		
	right elbow.				falls were audited per MDS		
					coordinator on 3/27/24 and for	und	
		rd for Resident 16 was reviewed			to be accurate.		
		0 p.m. The medical diagnosis			What measures will be put into		
	included dementia.				place or what systematic chan	_	
					will be made to ensure that the		
		ssessment, dated 9/26/2023,			deficient practice does not rec		
		lent 16 had one fall without			MDS Coordinator was educate		
	injury during that re	eview period.			on the accuracy of assessmer	nts	
					by Regional MDS Nurse on		
		note for Resident 14, dated			3/27/24. MDS coordinator will		
		d she had a fall that resulted in			audit all fall assessments mon	thly	
	nead laceration requ	uiring staples for closure.			to ensure accuracy of		
	An introdicainlin	unote for Decident 14 dated			assessments and report any	io	
		note for Resident 14, dated d she had slid off the bed			findings to the Administrator v		
		d she had shd off the bed			the QAPI process. Additionally		
	without injury.				any staff that fails to comply we the points of this in-service will		
	An interview with t	he MDS Nurse on 03/27/24			further educated and/or discip		
		ted that the facility codes MDS			as indicated.	ııı l e u	
		Resident Assessment			How the corrective actions will	l he	
	Instrument. After re				monitored to ensure the defici		
		essments, she will be entering			practice will not recur? (what (
		cords to accurately reflect the			program will be put into place		
	falls.	to accurately reflect the			how often checked)	anu	
	Iulio.				MDS coordinator will audit Se	ction	
			ı		I MIDO COOLGINATOI WIII AUGIT SE	ouon i	

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/28/2024
	ROVIDER OR SUPPLIER OF RUSHVILLE S	KILLED NURSING FACILITY, THE	612 E 1	ADDRESS, CITY, STATE, ZIP COD 11TH ST /ILLE, IN 46173	
(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 APPROPRI DEFICIENCY)	5.112
				J on the MDS assessments for accuracy of assessments for random residents weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random residents weekly x 4 months. the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAP meeting, the monitoring will be reviewed. Any concerns will been corrected as found. Any patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29 2024	nts dom If e l e nave y I be y or
F 0684 SS=D Bldg. 00	applies to all treatifacility residents. E comprehensive as facility must ensur treatment and care professional stand	a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive in accordance with lards of practice, the erson-centered care plan,	F 0684	F684 Quality of Care:	04/29/2024
	Based on observation	ons, interview, and record	1 0007	It is the policy of this facility to	

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 3 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155053	B. WING	<u> </u>	03/28/2024	
			CTREET	ADDRESS CITY STATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF RUSHVILLES	SKILLED NURSING FACILITY, THE		/ILLE, IN 46173		
			, 1	T		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION failed to accurately monitor	TAG		DATE	
		ng per physician order for 2 of		ensure accurate monitor residuith bruises.	enis	
	3 residents reviewe			What corrective actions will	ho	
	5 residents reviewe	d for ordising.		accomplished for those	De	
	Findings include:			residents found to have been	n	
	i manigo metade.			affected by the deficient		
	1. The clinical reco	rd for Resident 14 was reviewed		practice?		
		5 p.m. The medical diagnosis		Resident 14 & 21's progress r	notes	
	included dementia.			were updated on 3/26/24 with	I	
				negative outcome related to the	I	
An Annual Minimum Data Set (MDS)			alleged deficient practice by the	I		
	Assessment, dated 1/27/2024, indicated Resident			DON.		
	14 was cognitively impaired and at risk for			How other residents having	the	
	developing skin impairments, but did not have			potential to be affected by the	I	
	any alternations in skin.			same deficient practice will I	I	
	-			identified and what corrective		
	A bruising care plan	n, dated 2/6/2020, indicated to		actions will be taken?		
	monitor skin daily	during care.		The DON/Designee complete	d an	
				audit on 3/26/24 of all residen	ts	
	A physician order f	or Resident 14, dated		requiring monitoring for skin		
	12/14/2022, indicat	ed to monitor three times a day		conditions to ensure that all		
	for chronic bruising	g to her bilateral arms.		residents affected had adequa	ate	
				notes regarding their condition	ns for	
		for Resident, dated 1/24/2022,		monitoring.		
		ent 14 to utilize aspirin 81		What measures will be put in	nto	
	milligrams (mg) ev	ery day.		place or what systematic		
		2/25/2024 - 11 25		changes will be made to		
		3/25/2024 at 11:37 a.m.		ensure that the deficient		
		itting in the common area in		practice does not recur?		
		e was noted to have long		The DON/Designee in-service	ed the	
		ightly pulled up. A moderate		nursing staff on policy for		
		scabbed area was noted to her		standards of practice relating		
	left forearm.			monitoring of skin conditions of	on	
	Davious of the tor-t	mont administration record for		4/18/24, and proper		
		ment administration record for		documentation of all skin	rin a	
		ed that the bruising had been		conditions that require monito	•	
	3/26/2024.	2024 and the morning of		per physician orders. Any sta	I	
	3/20/202 4 .			that fails to comply with the po	I	
				of this in-service will be furthe	I I	

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

The nursing progress notes did not reflect the

Event ID:

NKHO11

Facility ID: 000018

If continuation sheet

educated and/or disciplined as

Page 4 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155053	B. WI	NG		03/28/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			1TH ST		
\\\\ATEDG	S OE BUSHVILLE S	KILLED NURSING FACILITY, THE	:		/ILLE, IN 46173		
VVATERS	Of ROOFFVILLE S	MILLED NONGING FACILITY, THE		1.03110	ILLE, IN 40173		
(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
		area until 3/26/2024 at 4:05			indicated.		
		ote indicated Resident 14 had a			How the corrective actions w	/ill	
		d 2.5 cm (centimeter) by 5.4 cm			be monitored to ensure the		
	with a scabbed area	measuring 0.6 cm by 0.1 cm.			deficient practice will not		
	0.771 1: 1	16 D :1 (2)			recur? (what QA program wi	II	
		rd for Resident 21 was reviewed			be put into place and how		
		14 a.m. The medical diagnosis			often checked)		
	included atrial fibri	liation.			DON/Designee will audit		
	A clain agus mlan 1-	stad 10/11/2010 indicated to			documentation of skin condition		
	-	ated 10/11/2019, indicated to 1's skin daily during care.			5 times a week x 4 weeks, the	en 3	
	momtor Resident 2	is skill daily during care.			times a week x 4 weeks, then		
	A physician's order, dated 5/31/2023, indicated				once a week x 4 months in the		
	that Resident 14 received blood thinning				morning clinical meeting to en that monitoring is being compl		
		day for atrial fibrillation.			in accordance with standards		
	incurcation twice a	day for atrial fromhation.			practice. DON/Designee will	Oi	
	Δ nhysician's order	, dated 5/17/2023, indicated to			utilize the treatment record of		
		ns and Symptoms of			each residents and check for a	a	
	_	every shift. Document unusual			corresponding progress note t		
	findings in progress				ensure monitoring is done pe		
	8 F8	. —————————————————————————————————————			physician order. If the facility		
	During an interview	and observation on 3/25/2024			within 95% compliance at the		
	-	lent 14 was noted to have a			of the months, the monitoring		
		left posterior hand near the			be stopped. At the monthly QA		
		ed she did not know how she			meeting, the monitoring will be		
	received this bruise	and that it was fading.			reviewed. Any concerns will h		
		C			been corrected as found. Any		
	Review of the treats	ment administration record for			patterns will be identified. If		
	Resident 16 indicate	ed that the bruising had been			necessary, an Action Plan will	be	
	monitored on 3/25/2	2024 and the morning of			written by the committee. Any	/	
	3/26/2024.				written Action Plan will be		
					monitored by the Administrato	r	
	The nursing progres	ss notes did not reflect this			weekly until resolution.		
		24 at 5:36 p.m. The nursing					
		dent 16 had a bruise that			By what date the systemic		
	measured 2.0 cm (c	entimeter) by 1.5 cm.			changes will be completed?		
					Date of Compliance: April 29,		
		Physician order - (Following			2024		
		was provided by the Regional					
	Nurse Consultant of	n 3/27/2024 at 2:00 p.m. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (00) COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPL	
		155053	B. WIN	<u> </u>		03/28/	2024
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, TH	E	STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	policy indicated, "It follow the orders of	t is the policy of the facility to the physician"					
	3.1-37(a)						
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre- Based on the com a resident, the fac- (i) A resident rece professional stand pressure ulcers ar pressure ulcers ur condition demonsi unavoidable; and (ii) A resident with necessary treatments	ssure ulcers. aprehensive assessment of ility must ensure that- ives care, consistent with dards of practice, to prevent and does not develop aless the individual's clinical trates that they were pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent					
	Based on observation review the facility of relieving intervention for a resident with a (full thickness tissue eschar) on the right reviewed for pressu	on, interview, and record ailed to implement a pressure on as ordered by the podiatrist an unstageable pressure ulcer e loss ulcer covered by heel for 1 of 2 residents re ulcers (Resident 4).	F 068	36	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer: It is the policy of this facility to implement a pressure relieving interventions as ordered by the MD. What corrective actions will a accomplished for those residents found to have been	e b e	04/29/2024
	Resident 4 on 3/25/2 had a pressure ulcer physician told her o in his office. The re	ion and interview with 24 at 1:06 p.m., indicated she on her right heel, the on 3/21/24 when she seen him sident indicated the physician ff the ground. The resident			affected by the deficient practice? Resident 4 was provided with boot to keep her foot off the ground on 3/27/24 by the DON with no negative outcome relate to this alleged deficient practic. How other residents having the practice of the process of the practice of the	N ted :e.	

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 6 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	TED
		155053	B. WI	NG		03/28/2	.024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			1TH ST		
WATERS	OF RUSHVILLE S	KILLED NURSING FACILITY, THE	<u> </u>		/ILLE, IN 46173		
			<u> </u>		, I	Т	OUE:
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG			DATE
was observed to be sitting in her wheelchair with her right heel directly on the floor.				potential to be affected by the same deficient practice will be			
	nei right heef dheet	ry on the moor.			identified and what corrective		
	During an observati	on on 3/26/24 at 11:05 a.m.,			actions will be taken?	e	
	-	ng in the dining room with her			The DON/Designee completed	hae h	
	right heel on floor.	ing in the diffing room with her			audit for pressure relieving	u anu	
	right neer on moor.				interventions on 4/18/24. Any		
	During an observati	on and interview on 3/26/24 at			concerns were immediately		
	-	at 4 sitting in her room in			addressed.		
	_	right heel on the floor, she			What measures will be put in	nto	
		orn an off-loading boot			place or what systematic		
		been offered one with this			changes will be made to		
pressure ulcer on her right heel. The resident				ensure that the deficient			
indicated she would be willing to wear one now.				practice does not recur?			
The resident indicated she did have some pain				The DON/Designee in-service	ed the		
		e right heel pressure ulcer.			nursing staff on preventing an		
	•				healing pressure ulcers on		
	During an observati	on on 3/26/24 at 2:11 p.m.,			4/18/24, with emphasis on		
	Resident 4 was sitti	ng in her wheelchair in dining			providing pressure-relieving		
	room with right hee	l on the ground.			devices to residents that requi	ire	
					them. Additionally, any staff the		
	During an interview	the Director of Nursing			fails to comply with the points	of	
	(DON) on 3/26/24 a	at 2:23 p.m., indicated the nurse			this in-service will be further		
	who received the or	der from the podiatrist should			educated and/or disciplined as	S	
	-	nn intervention to keep			indicated.		
	Resident 4's right he	eel off the floor.			How the corrective actions w	vill	
					be monitored to ensure the		
	-	on and interview with			deficient practice will not		
		24 at 2:27 p.m., indicated the			recur? (what QA program wi	II	
		el was between a 2-3 on pain			be put into place and how		
		constant, it's just enough to			often checked)		
		esident was pleased to know			DON/Designee will audit 4 rar	ndom	
	-	ald be offering her pressure			residents that have wounds		
		e resident remained in the			weekly for 4 weeks, then 3		
	dining room with he	er right heel on the floor.			random residents weekly for 4		
					weeks, then 2 random resider		
		d of Resident 4 on 3/27/24 at			weekly x 4 months, to ensure		
		ized osteoarthritis, soft tissue			residents are being offloaded	from	
		eakness, venous insufficiency			pressure and have a		
	and congestive hear	t failure.			pressure-relieving device in pl	ace.	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155053	B. W	ING		03/28	/2024
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
\4/4.TED	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NAME OF A SHARWARD FACILITY. THE	_		1TH ST		
WATERS	OF RUSHVILLE S	SKILLED NURSING FACILITY, THE	=	RUSHV	/ILLE, IN 46173		
(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	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					If the facility is within 95%		
	The Quarterly Mini	mum Data (MDS) assessment			compliance at the end of the 6	6	
		cated the resident was			months, the monitoring will be		
		or daily decision making. The			stopped. At the monthly QAPI		
		tent and reasonable. The			meeting, the monitoring will be		
		of developing a pressure			reviewed. Any concerns will h		
	ulcer.				been corrected as found. Any		
					patterns will be identified. If		
	The podiatrist seen	the resident on 3/21/24 and			necessary, an Action Plan will	be	
	_	e ulcer on the right heel. The			written by the committee. Any		
	_	he resident to keep heel off the			written Action Plan will be		
	ground.	1			monitored by the Administrato	r	
	8				weekly until resolution.	•	
	The plan of care for	r Resident 4, dated 3/22/24,					
		nt had a wound on the right			By what date the systemic		
		ons included, but were not			changes will be completed?		
) encourage the resident to keep			Date of Compliance: April 29,		
		e ground per physician order			2024		
	_	arage the resident to wear a					
		heel was not elevated.					
	The wound care not	te for Resident 4, dated					
		he resident went to the					
		toenails clipped, while the					
	l	he physician found an					
		e injury on the right heel. The					
		neter (cm) by 0.5 cm 100%					
		t had no drainage and had					
	pain of a 2 on the 1	_					
	1	1					
	The physician order	r policy provided by the Nurse					
		/24 at 2:00 p.m., indicated the					
		uld follow the orders of the					
	physician.						
	3.1-40(a)(2)						
F 0688	483.25(c)(1)-(3)						
SS=D	1 ' ' ' ' ' '	Decrease in ROM/Mobility					
Bldg. 00	§483.25(c) Mobilit						

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 8 of 30

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155053	B. WI	NG		03/28	/2024
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			1TH ST		
WATERS	S OF RUSHVILLE S	SKILLED NURSING FACILITY, THE	=		/ILLE, IN 46173		
	TOOTVILLE C	THE THE PROPERTY OF THE PROPERTY OF THE	-	1.0011	TEEE, IIV TO 170		
(X4) ID	SUMMARY	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
	- , , , ,	e facility must ensure that a					
		rs the facility without limited					
	_	oes not experience					
	_	e of motion unless the					
		condition demonstrates					
		range of motion is					1
	unavoidable; and						
	8/83 25(0)(2) / 5	esident with limited range of					
	- , , , ,	ppropriate treatment and					
		se range of motion and/or to					
		crease in range of motion.					
	provont faither de	areas in range of motion.					
	\$483,25(c)(3) A re	esident with limited mobility					
	- , , , ,	ate services, equipment, and					
		ntain or improve mobility					
		n practicable independence					
	unless a reduction						
	demonstrably una	-					
			F 06	588	F 688 Increase/Prevent		04/29/2024
		observation, and record			Decrease in ROM/Mobility:		
	_	failed to ensure a left-hand			It is the policy of this facility to		
	•	vas available for 1 of 1 resident			ensure splints or braces area		
	reviewed for contra	ectures. (Resident 2)			available for residents with		
					contractures.		
	Findings include:				What corrective actions will	be	
	TEL 11 1 1	C D 11 42			accomplished for those		
		for Resident 2 was reviewed on			residents found to have been	1	1
	_	.m. The medical diagnosis			affected by the deficient		
	included heart failu	10.			practice?	0	
	An Annual Minimu	ım Data Set Assessment			Resident 2's and Resident 10'	5	
		m Data Set Assessment 10 had moderate cognitive			doctor were notified of the	4	1
	impairment.	10 had moderate cognitive			missing braces on 3/26/24 and ordered that facility could use		
	ппрантиси.				rolled up washcloth or facility	a	
	An interview and of	bservation with Resident 10 on			carrot until brace could be		
		.m. indicated that her left hand			replaced. New braces were		
		es and her contracture to the			ordered on 3/28/24.		1
		ned. She stated they used to			How other residents having	the	
		left palm about a year ago, but			potential to be affected by th		

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 9 of 30

05/02/2024 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 03/28/2024 155053 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 612 E 11TH ST WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE **RUSHVILLE, IN 46173** (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 the staff "gave up on using it after it was lost. She same deficient practice will be was open to trying to utilize something to her left identified and what corrective hand for her contractures. She stated there is actions will be taken? nothing in her room they used for her hand, and All residents have the potential to nothing was visible on the surfaces like a hand be affected. The DON/Designee brace or palm protector. completed audit all braces worn by residents to ensure that they An interview and observation with Resident 2 on are available and is in use by 3/26/2024 at 1:00 p.m. indicated that no one placed residents per their physician anything in her hand last night and no brace or orders. This audit was completed palm protector was visible in her room. on 4/18/24. What measures will be put into A physician's order, dated 2/22/2023, indicated for place or what systematic Resident 2 to utilize a left-hand protector at night changes will be made to rime to improve left hand range of motion. Thie ensure that the deficient order was placed on hold on 3/26/2024. practice does not recur? The DON/Designee in-serviced the An interview with the Regional Nurse Consultant nursing staff on following physician on 3/27/2024 at 1:20 p.m. indicated that she was orders for all braces/splints and unable to find the protector for Resident 2's hand reporting when splint or brace is in her room, so she received an order from the not available on 4/18/24. physician to place it on hold and utilize a rolled Additionally, any staff that fails to washcloth or therapy carrot. comply with the points of this in-service will be further educated A policy entitled, "Physician order - (Following and/or disciplined as indicated. Physician Orders)", was provided by the Regional How the corrective actions will Nurse Consultant on 3/27/2024 at 2:00 p.m. The be monitored to ensure the policy indicated, "It is the policy of the facility to deficient practice will not follow the orders of the physician ..." recur? (what QA program will be put into place and how 3.1-42(a)(2)often checked) DON/Desginee will audit all residents who have brace/splint orders and randomly check 2 residents per week for 6 months to ensure that devices are in use and used properly per physician orders. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be

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

Event ID:

NKHO11

Facility ID: 000018

If continuation sheet

Page 10 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155053	B. WI	NG		03/28/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			612 E 1	1TH ST		
WATERS	OF RUSHVILLE S	KILLED NURSING FACILITY, THE		RUSHV	ILLE, IN 46173		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervisi §483.25(d) Accide The facility must e §483.25(d)(1) The remains as free of possible; and §483.25(d)(2)Each adequate supervis to prevent accident Based on interview,	ents. ensure that - eresident environment faccident hazards as is en resident receives sion and assistance devices	F 06	TAG 89	stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will heen corrected as found. Any patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29, 2024 F 689 Free of Accident Hazar Supervision Devices:	e nave be r	O4/29/2024
	in place for a reside	nt while in bed for 1 of 3 for falls. (Resident 7)			It is the policy of this facility to ensure fall mats are in place we residents are in bed.	/hile	
	Findings include:				What corrective actions will accomplished for those residents found to have been		
		for Resident 7 was reviewed on a.m. The medical diagnosis			affected by the deficient practice? Resident 7's fall mat was place	ed	

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 11 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155053	B. W	ING		03/28/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				1TH ST		
WATERS	OF RUSHVILLE S	KILLED NURSING FACILITY, THE	Ξ		/ILLE, IN 46173		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		J	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					on 3/27/24 by the DON with no	0	
	A Ouarterly Minim	um Data Set Assessment,			negative outcome related to the		
dated 2/15/2024, indicated that Resident 7 was				alleged deficient practice.			
	cognitively impaire				How other residents having	the	
					potential to be affected by th		
	A nursing assessme	nt, dated 3/22/2024, indicated			same deficient practice will be		
		at high risk for falls.			identified and what correctiv		
		-			actions will be taken?		
	A physician order, o	dated 1/3/2023, indicated for			All residents have the potentia	al to	
		ve a mat on the floor by her			be affected. The DON/Design		
	bed, while she is in	it"			completed an audit on 3/27/24	lof	
					all residents with fall/injury		
An observation on 3/25/2024 at 11:46 a.m.,				prevention mats.			
indicated Resident 7 was laying in her bed at this				What measures will be put in	ito		
time with her fall mat folded in three and stored				place or what systematic			
	between the foot of	her bed and closet.			changes will be made to		
					ensure that the deficient		
	An observation on 3	3/25/2024 at 1:20 p.m.,			practice does not recur?		
	indicated Resident	7 was laying in her bed at this			The DON/Designee in-service	d the	
		at folded in three and stored			nursing staff on 4/18/24 on the		
		her bed and closet. She had a			importance of ensuring fall ma	its	
	bottled drink in her	hand at this time.			are in place when ordered. Ar	-	
					staff that fails to comply with the		
		interview with CNA 2 on			points of this in-service will be		
	_	.m. indicated Resident 7 should			further educated and/or discip	lined	
		ace and Resident 7 was			as indicated.		
	observed with her fa	all mat in place.			How the corrective actions w	/ill	
					be monitored to ensure the		
		he Regional Nurse Consultant			deficient practice will not	.	
		5 p.m. indicated that nursing			recur? (what QA program wi	"	
	_	e for ensuring the use of fall			be put into place and how		
	interventions.				often checked)		
	A nation antitled "	Guidalinas for			DON/Designee will audit 5 ran		
	A policy entitled, "(residents to ensure placement	ı OI	
		Falls", was provided by the 27/2024 at 10:30 a.m. The			fall mats for 4 weeks, then 3 random residents a week x 4		
		Based on the results of				, to o	
		all, the resident's care plan will			weeks, then 3 random residen		
		ure that any needed point of			month x 4 months If the faction within 05% compliance at the	-	
		ble goals with appropriate			is within 95% compliance at the	ie	
	10cus nave measura	ore goars with appropriate	I		end of the 6 months, the		

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/28/2024
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	612 E 1	ADDRESS, CITY, STATE, ZIP COD 1TH ST /ILLE, IN 46173	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
F 0692	interventions in place 3.1-45(a)(2) 483.25(g)(1)-(3)	ce"		monitoring will be stopped. monthly QAPI meeting, the monitoring will be reviewed concerns will have been co as found. Any patterns will identified. If necessary, an Plan will be written by the committee. Any written Act Plan will be monitored by th Administrator weekly until resolution. By what date the systemic changes will be completed Date of Compliance: April 2	. Any rrected be Action ion ie
SS=D Bldg. 00	Nutrition/Hydration §483.25(g) Assiste (Includes naso-ga tubes, both percut gastrostomy and piejunostomy, and resident's compres facility must ensur §483.25(g)(1) Mai parameters of nutrusual body weight range and electrol resident's clinical of that this is not pospreferences indicated §483.25(g)(2) Is of to maintain proper §483.25(g)(3) Is of	ntains acceptable ritional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident			

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet

Page 13 of 30

	T OF PERIODE			allown tromport	OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>	COMPLETED	
		155053	B. WING		03/28/2024	
NAME OF I	PROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZIP COD		
			612 E 11TH ST			
WATERS	OF RUSHVILLE S	SKILLED NURSING FACILITY, TI	HE RUSH	VILLE, IN 46173		
(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 APPROPRIAT	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	health care provid	ler orders a therapeutic diet.				
			F 0692	F692 Nutrition/Hydration Stat	us 04/29/2024	
		and record review, the facility		Maintenance:		
	failed to timely ente	er a resident with a significant		It is the policy of this facility to		
	weight loss into the	Skin and Weight Assessment		ensure proper nutrition and		
	Team (SWAT) prog	gram for 1 of 3 residents		hydration for all residents.		
	reviewed for signifi	icant weight loss.		What corrective actions will be	oe e	
				accomplished for those		
	Findings include:			residents found to have been		
				affected by the deficient		
	The clinical record	for Resident 14 was reviewed		practice?		
	on 3/25/2024 at 2:4	5 p.m. The medical diagnosis		Resident 14 was added to the		
	included abnormal	weight loss.		SWAT program 3/27/2024, with	th	
				interventions added to her care	e	
	Weights for Reside	nt 14 were record as:		plan. Resident 14 reviewed by		
	2/1/2024 - 99.8 lbs.	(pounds)		registered dietician and		
	3/1/2024 - 94.3 lbs.	(-5.51% from 2/1/2024)		recommendations to be followed	ed	
	3/2/2024 - 92.1 lbs.	(-7.72% from 2/1/2024)		4/25/24.		
				How other residents having the	he	
	A SWAT note, date	ed 3/21/2024, indicated new		potential to be affected by the	•	
	interventions of inc	luding a power pudding to the		same deficient practice will b	e	
	lunch tray for Resid	lent 14.		identified and what corrective)	
				actions will be taken?		
	An interview with t	he Regional Nurse Consultant		All residents have the potential	to	
	on 3/27/2024 at 1:2	0 p.m. indicated that no SWAT		be affected. The DON/Designo	ee	
	notes were found fo	or Resident 14 between		completed an audit on 3/27/24	of	
	3/1/2024 and 3/21/2	2024.		all residents to determine weig	ht	
				losses and ensure that all		
	A policy entitled, "	SWAT PROGRAM (SKIN		residents are being reviewed b	у	
	AND WEIGHT AS	SSESSMENT TEAM)" was		the SWAT team for significant		
	provided by the Re	gional Nurse Consultant on		changes in weight. The		
	3/26/2024 at 10:55	a.m. The policy indicated, "It		DON/Designee will ensure that	all	
		facility to assess the		recommendations of the SWA	Г	
	nutritional status of	each residentThese		team are addressed and		
	residents will be mo	onitored through this team		implemented into the resident's	3	
	improvement of the	e resident's nutritional status".		plan of care.		
Indicators to determine implementation of the			What measures will be put in	to		
	SWAT monitoring	for a resident would include, "		place or what systematic		
		ht change (undesirable) in 30		changes will be made to		

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

days ..." and that the SWAT will " ...meet weekly

Event ID:

NKHO11

Facility ID: 000018

ensure that the deficient

If continuation sheet

Page 14 of 30

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155053	A. BUILDING B. WING	00	COMPLETED 03/28/2024
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	612 E 1	ADDRESS, CITY, STATE, ZIP COD 1TH ST ILLE, IN 46173	
(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
		in need of addressing currant letermine appropriate		practice does not recur? The DON/Designee in-service nursing staff on the SWAT teat policy on 4/18/24, and the importance of reviewing and implementing interventions to address weight loss. How the corrective actions we be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked) DON/Designee will monitor residents daily in the morning clinical meeting for weight changes and referred to SWA' times a week x 4 weeks, then times a week x 4 weeks, then once a week x 4 weeks, then once a week x 4 months. DON/Designee will ensure that recommendations per SWAT team, will be implemented into resident's plan of care. At the monthly QAPI meeting, the monitoring will be reviewed. At concerns will have been correas found. Any patterns will be identified. If necessary, an Act Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. After six months of least 95% compliance, monito can be stopped, but daily monitoring of weights will cont on an on-going basis. By what date the systemic	rill II T 5 3 It all I the Chany Cted It inn If at ring

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet

Page 15 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE COMPL 03/28 /	ETED	
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE		612 E 1	.ddress, city, state, zip cod 1TH ST ILLE, IN 46173		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	(X5) COMPLETION DATE
					changes will be completed? Date of Compliance: April 29, 2024	,	
F 0710 SS=D Bldg. 00	§483.30 Physician A physician must puriting a recomme be admitted to a faremain under the ophysician, physician, physician, physician, physician, provide orders for care and needs. §483.30(a) Physic The facility must established the facility must established the superviolation of the medical care of attending physicians. Based on interview failed to timely information significant weight consideration of the clinical record on 3/25/2024 at 2:4 included abnormal stables.	personally approve in endation that an individual acility. Each resident must care of a physician. A an assistant, nurse nical nurse specialist must the resident's immediate sian Supervision. Insure that- Insure that- Insure that- Insure the physician supervises of residents when their is unavailable. In and record review, the facility orm Resident 14's provider of a hange for 1 of 3 residents onal needs. In the medical diagnosis weight loss. Interpretation of the provider of the provi	F 071	10	F 710 Residents Care Supervised by Physician: It is the policy of this facility to ensure that all residents' care supervised by a physician. What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Resident 14's physician was notified of her weight loss on 3/28/24 resident was referred our SWAT (skin and weight)	is be n	04/29/2024
	3/1/2024 - 94.3 lbs.	(-5.51% from 2/1/2024)			program by the DON.		

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet

Page 16 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155053	B. WI	NG		03/28/2	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			I1TH ST		
WATERS	S OF RUSHVILLE S	KILLED NURSING FACILITY, TH	=		/ILLE, IN 46173		
	· · · · · · · · · · · · · · · · · · ·	THE THE TAIL THE THE TAIL THE TAIL THE TAIL THE TAIL THE		1100111	1		
(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
	3/2/2024 - 92.1 lbs. (-7.72% from 2/1/2024)				How other residents having		
		. 6			potential to be affected by th		
		y note from 3/21/2024, that			same deficient practice will be		
		14's weight loss, did not			identified and what correctiv	e	
		ans was notified of the weight			actions will be taken?		
	loss.				The DON/Designee completed		
	An intervious with t	he Regional Nurse Consultant			audit on all residents experien	-	
		0 p.m. indicated she could not			significant weight changes on 4/1/24 and verified they had a		
		al record where the attending			appropriate physician notificat		
		ied of the significant weight			What measures will be put in		
	loss for Resident 14	-			place or what systematic	10	
	1033 101 Resident 1-	r.			changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					The DON/Designee in-service	nd the	
					nursing staff on SWAT policy		
					notification of physician for all		
					significant weight losses and/o		
					gains. Additionally, any staff th		
					fails to comply with the points		
					this in-service will be further	-	
					educated and/or disciplined as	3	
					indicated.		
					How the corrective actions w	/ill	
					be monitored to ensure the		
					deficient practice will not		
					recur? (what QA program wi	H	
					be put into place and how		
					often checked)		
					DON/Designee will audit		
					significant weight changes we	ekly	
					via SWAT program and ensur		
					physician notification has been	n	
					made and documented on all		
					changes x 6 months. If the fa	cility	
					is within 95% compliance at the	ie	
					end of the 6 months, the		
					monitoring will be stopped. At	the	
			1		monthly QAPI meeting the		

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155053	B. W	ING		03/28	/2024
NAME OF I	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP COD		
					I1TH ST		
WATERS	OF KUSHVILLE	SKILLED NURSING FACILITY, TI	7E	KUSHV	/ILLE, IN 46173		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG	monitoring will be reviewed.	 Дnv	DATE
					concerns will have been corre	-	
					as found. Any patterns will be		
					identified. If necessary, an A	ction	
					Plan will be written by the		
					committee. Any written Action	า	
					Plan will be monitored by the		
					Administrator weekly until		
					resolution.		
					By what date the systemic		
					changes will be completed?		
					Date of Compliance: April 29		
					2024		
F 0727	183 35(h)(1) (2)						
SS=F	483.35(b)(1)-(3)	Wk, Full Time DON					
Bldg. 00	§483.35(b) Regis						
	- , , -	cept when waived under					
	. , , , ,	(f) of this section, the facility					
		vices of a registered nurse					
		secutive hours a day, 7 days					
	a week.						
	8483 35(h)(2) Ev	cept when waived under					
	` ', ' '	(f) of this section, the facility					
	,	registered nurse to serve					
	_	nursing on a full time basis.					
	- ' ' ' '	e director of nursing may					
	_	e nurse only when the facility					
	has an average d fewer residents.	aily occupancy of 60 or					
	iewei iesidenis.		F 0	727	F 727 RN Coverage:		04/29/2024
	Based on interview	and record review, the facility	1 0	141	It is the policy of this facility to)	07/2//2024
		tht hours of consecutive RN			ensure a registered nurse is		
		1 days reviewed. This deficient			available for 8 hours a day, 7	days	
	practice had the po	tential to affect 34 residents.			a week.	-	
					What corrective actions will	be	
	Findings include:				accomplished for those		

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet

Page 18 of 30

NAME OF PROVIDER OR SUPPLIER WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE RUSHVILLE IN 46173 WISHVILLE IN 46174 TAO PREFIX TUSHVILLE IN 46174 TAO	STATEMEN	T OF DEFICIENCIES	EFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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An interview with Regional Nurse Consultant on 3/27/2024 at 1:20 p.m. indicated that the facility was unable to find RN coverage for that time. During that time, they were utilizing their own staff and agency, but could not fill RN coverage consistently. An interview with Regional Nurse Consultant on 3/27/2024 at 2:20 p.m. indicated they did not have a specific policy for RN coverage, but the facility would follow the Center for Medicare and Medicaid regulation. Medicaid regulation. An interview with Regional Nurse Consultant on 3/27/2024 at 2:20 p.m. indicated they did not have a specific policy for RN coverage, but the facility would follow the Center for Medicare and Medicaid regulation. Medicaid regulation. Scheduler) on the policy "Registered Nurse Coverage" on 4/18/24. Any employee who fails to meet the points of the in-service will be further educated. How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked) The daily schedule will be		facility.				therefore, this plan of correction	on		
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recur? (what QA program will be put into place and how often checked) The daily schedule will be									
be put into place and how often checked) The daily schedule will be						<u>-</u>	11		
often checked) The daily schedule will be									
The daily schedule will be						_			
						•			
reviewed, during morning						-			
meeting, 5 times per week x 4							4		
weeks, weekly x 4 weeks then									

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/28/2024		
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173				
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4) Drug Regimen Re On §483.45(c) Drug F §483.45(c)(1) The resident must be r month by a license §483.45(c)(2) This	(5) view, Report Irregular, Act Regimen Review. drug regimen of each eviewed at least once a		monthly x 4 months, ensure coverage is conducted 7 da each week (8 consecutive hours) If the facility is within compliance at the end of the months, the monitoring will be stopped. At the monthly QAP meeting, the monitoring will be reviewed. Any concerns will been corrected as found. An patterns will be identified. If necessary, an Action Plan wi written by the committee. An written Action Plan will be monitored by the Administrative weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29 2024	PRN ys 100% 6 e Pl De have y II be Dy or		
	§483.45(c)(4) The any irregularities t and the facility's m of nursing, and the upon.	pharmacist must report to the attending physician medical director and director ese reports must be acted clude, but are not limited					

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 20 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. W	JILDING	00	COMPLETED 03/28/2024	
		155053	B. W	_		03/28/	2024
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
WATERS	S OF RUSHVILLE S	SKILLED NURSING FACILITY, TH	F		I 1TH ST /ILLE, IN 46173		
	T		<u> </u>		T		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
TAG	`	R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		neets the criteria set forth					
		of this section for an					
	unnecessary drug						
		es noted by the pharmacist					
	_	must be documented on a report that is sent to the					
	-	an and the facility's medical					
		tor of nursing and lists, at a					
		ident's name, the relevant					
	_	gularity the pharmacist					
	identified.						
		physician must document					
		nedical record that the rity has been reviewed and					
	_	n has been taken to					
	· ·	e is to be no change in the					
		ttending physician should					
	document his or h	ner rationale in the resident's					
	medical record.						
	\$492.45(a)(5) The	e facility must develop and					
		and procedures for the					
		men review that include, but					
		time frames for the different					
	steps in the proce						
		take when he or she					
	_	ularity that requires urgent					
	action to protect the	ne resident.	F 0	756	F 756 Drug Regimen Review	,.	04/29/2024
	Based in interview	and record review, the facility	1 0	730	It is the policy of this facility to		04/29/2024
		t a pharmacy recommendation			ensure that all pharmacy		
	was completed in a	timely manner for 1 of 5			recommendations are follow u	p on	
		for pharmacy services.			in a timely manner.		
	(Resident 2)				What corrective actions will	pe	
	Findings include:				accomplished for those	_	
	Findings include:				residents found to have beer affected by the deficient	1	
	The clinical record	for Resident 2 was reviewed on			practice?		
		o.m. The medical diagnosis			Resident 2's drug regimen wa	s	
	included heart failu				reviewed and recommendation		

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

Event ID:

NKHO11 Facility ID: 000018 If continuation sheet Page 21 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		(X2) MULTIPLE C A. BUILDING B. WING	<u> </u>		(X3) DATE SURVEY COMPLETED 03/28/2024	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	612 E	r address, city, state, zip co 11TH ST IVILLE, IN 46173	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION JULD BE PROPRIATE	(X5) COMPLETION DATE
TAG	An Annual Minimi indicated Resident impairment. A pharmacy recom 10/15/2023, contair regarding a gradua antidepressant. This signed by a practiti with the reduction A correlating physic reduction in Reside entered in the medical entered in the medical entered in the medical further information pharmacy recommendation. A policy entitled, "Procedure-Pharmacy provided by the Reside 3/26/2024 at 1:45 presponse as to the atthe Pharmacy Constitution."	am Data Set Assessment 10 had moderate cognitive amendation, printed on ned a recommendation I dose reduction of Resident 2's s recommendation was not oner until 12/14/2023 agreeing in her antidepressant. Ician order to reflect the ent 2's antidepressant was ical record on 12/19/2023. Ithe Regional Nurse Consultant 20 p.m. indicated she had no a to provide regarding the endation. Policy and ey Recommendations", was regional Nurse Consultant on b.m. The policy indicated, " A action to be taken regarding sultant's recommendation will thin 7 days of the receipt of the	TAG	were initiated on 12/14/2 negative outcome from the deficient practice. How other residents has potential to be affected same deficient practice identified and what cornactions will be taken? The DON/Designee will pharmacy recommendate the last 90 and an conceive addressed by the phywhat measures will be place or what systemate changes will be made the ensure that the deficient practice does not recure the DON was in-serviced 3/27/24 by Regional Nurconsultant that all pharmacy recommendations will be by the DON/Designee and document the physician within 7 days of the receive Additionally, any staff the comply with the points of in-service will be further and/or disciplined as indeficient practice will in recur? (what QA prograte be put into place and hoften checked) The DON/Designee will the pharmacy recommendations are as by the physician within 7 are as as by the physician within 7 are as as as as as as as as	exing the liby the exiles alleged liby the exiles alleged liby the exiles all tions for erns will exican. I put into tic exic	DATE
1				receipt x 6 months. If th	-	

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

Event ID:

NKHO11 Facility ID: 000018

If continuation sheet Page 22 of 30

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/28/2024	
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	612 E 1	ADDRESS, CITY, STATE, ZIP COD 1TH ST /ILLE, IN 46173	
(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
				is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At monthly QAPI meeting, the monitoring will be reviewed. A concerns will have been corre as found. Any patterns will be identified. If necessary, an Ac Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29, 2024	the Any cted stion
R 0000					
Bldg. 00	Survey. This visit in State Licensure Sur Survey dates: March Facility number: 00 Residential Census: These State Resider accordance with 410	h 25, 26, 27 & 28 2024 0018 12 ntial Findings are cited in	R 0000	="" p=""> Preparation and/or execution of this plan of correctin general, or this corrective as in particular, does not constitute an admission of agreement by facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepare and/or executed in compliance with State and Federal Law. The Facility's date of alleged compliance is 4/29/2024. The Facility is respectfully requesting paper compliance for all	ction ction te this d

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 23 of 30

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2024		
	PROVIDER OR SUPPLIER	KILLED NURSING FACILITY, TH	ΙE	612 E 1	ADDRESS, CITY, STATE, ZIP COD 11TH ST /ILLE, IN 46173		
(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)	ATE.	(X5) COMPLETION DATE
					deficiencies in this POC.		
R 0246 Bldg. 00	a qualified medical authorization by a physician. The QN authorization for e PRN medication. In physician not on the authorization to act documented in the the time and date. Based on observation review, the facility of Medication Aide (Quantity of pre-authorization from the administering an "act to a resident. (Resident of the clinical recorded on 3-28-24 at 11:11 received a dose of the clinical recorded and the complexity of the clinical recorded on 3-28-24 at 11:30 a.m. administration recorded a dose of the clinical received and the complexity of the clinical recorded and the clinical received and the cli	Deficiency ons may be administered by tion aide (QMA) only upon licensed nurse or MA must receive appropriate ach administration of a All contacts with a nurse or the premises for dminister PRNs shall be a nursing notes indicating of the contact. On, interview and record failed to ensure a Qualified of MA) obtained a tom a licensed nurse prior to as needed, or PRN" medication lent R1) of Resident R1 was reviewed a.m. It indicated she had oxycodone, a narcotic, on, from QMA 4. The medication and (MAR) documented a r this medication indicated the ton 12-6-23, for oxycodone 5 1 tablet every 8 hours as	R 0	246	R 246 Health Services: It is the policy of this facility to ensure health services to our assisted living residents. What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Resident R1 was assessed by DON on 3/28/14 and had no negative outcome related to the alleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions will be taken? All residents have the potential be affected by this cited pract therefore, this plan of corrections.	be n y the his the he be ye al to ice,	04/29/2024
	administered to Res	_			applied to all residents of the facility. What measures will be put in place or what systematic	nto	

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 24 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		A. BUILDING <u>00</u> COM		(X3) DATE SURVEY COMPLETED 03/28/2024	
	ROVIDER OR SUPPLIER	KILLED NURSING FACILITY, THE	612 E	ET ADDRESS, CITY, STATE, ZIP COD E 11TH ST HVILLE, IN 46173	
(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 BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	4, she indicated if a	QMA administers a PRN [A is to check with one of the	TAG	changes will be made to ensure that the deficient	DATE
	licensed nurses of the	ne facility before the		practice does not recur? The DON/Designee in-service	ed the
	medication is administered and to place a notation in the progress note about which nurse provided the prior authorization.			nurses and QMA's that prior approval by the nurse is requ	
	-	3-28-24 at 12:35 p.m., with the		for a QMA to give a PRN medication on 4/18/24. The	
	Regional Nurse Con	nsultant, she indicated she		must document in the progre	ss
	could not locate a note of any type about the pre-authorization for the administration of oxycodone on 2-8-24 at 11:30 a.m., for Resident			give the medication or nurse sign off with the QMA on the	
	R1.	,		Medication Administration re-	
		3-28-24 at 2:30 p.m., with the insultant, she indicated the		points of this in-service will b	e
	_	ve a particular policy or QMA's administering PRN		as indicated. How the corrective actions	
	medications. She in State's scope of practices	ndicated the facility utilizes the etice.		be monitored to ensure the deficient practice will not	
	_	ment of Health's Long-Term		recur? (what QA program was be put into place and how	rill
	16.2-5 (2008) at 410	idential Regulations, 410 IAC O IAC 16.2-5-4(e)(6) references		often checked) DON/Designee will monitor the	
	may be administere	follows, "PRN medications d by a qualified medication		QMA's medication administration record daily in the morning cl	
	nurse or physician.	oon authorization by a licensed The QMA must receive		meeting for PRN medication administration five times a we	
	for each of a PRN n	eation for each administration medication. All contacts with a		4 weeks, then 3 times a week weeks, the once a week x 4	
	authorization to adn	not on the premises for ninister PRN's shall be nursing notes indicated the		months DON/Designee will check for a corresponding	
	time and date of the			progress note or sign off on t MAR by the nurse, if PRN medication was administered	
	2.5-1.4(e)(6)			the facility is within 95% compliance at the end of the	
				months, the monitoring will b stopped. At the monthly QAF	e
				meeting, the monitoring will be	

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 25 of 30

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155053		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 03/28/2024		
NAME OF PROVIDER OR SUPPLIER WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE		STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST RUSHVILLE, IN 46173				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE	
				reviewed. Any concerns will h been corrected as found. Any patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution.	be	
				By what date the systemic changes will be completed? Date of Compliance: April 29, 2024		
R 0298 Bldg. 00	(2) A consultant p employed, or und (A) be responsible in 856 IAC 1-7; (B) review the dru practices in the fa (C) provide consu procedures of ord administering, and as medication rec (D) report, in writin his or her designed dispensing or adn (E) review the dru	ervices - Deficiency harmacist shall be er contract, and shall: e for the duties as specified g handling and storage cility; ltation on methods and ering, storing, d disposing of drugs as well				
	Based on interview failed to have pharm medication every 9 reviewed for pharm	and record review the facility nacy review residents' 0 days for 4 of 7 residents acy services (Resident R1, R3, ad the potential to affect 8 of 14 facility stored and	R 0298	R298 Pharmaceutical Service It is the policy of this facility to ensure prescription narcotics a not administered to a resident without am appropriate prescription. What corrective actions will I	are	

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 26 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER			COMPLET	COMPLETED	
155053		B. WING 03/28/2024				024	
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					1TH ST		
WATERS	OF RUSHVILLES	KILLED NURSING FACILITY, THE	<u> </u>		'ILLE, IN 46173		
			-		,	<u> </u>	
(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	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	administered medic	ations to.			accomplished for those		
	Tr. 1 1 1				residents found to have beer	ו	
	Finding include:				affected by the deficient		
	D				practice?		
		rd of Resident R1 on 3/28/24 at			Resident R1, R3, R6 and R7 v		
		ed the resident's diagnoses			referred to Pharmacy Consulta	ant	
	· ·	not limited to , hypertension,			for review on 3/28/24 with no	,	
	disorder and edema	sorder, hemiplegia, anxiety			negative outcome related to the	IIS	
	disorder and edema	•			alleged deficient practice.	the l	
	Review of the recor	rd of Resident R3 on 3/28/24 at			How other residents having to		
		ed the resident's diagnoses			potential to be affected by th same deficient practice will be		
	_	not limited to, bipolar disorder,			identified and what correctiv		
		-			actions will be taken?	е	
	hypoxia, hypertension, lung cancer and malnutrition.				All residents have the potentia	l to	
	mamuurtion.				be affected by the cited practic		
	Review of the record of Resident R6 on 3/28/24 at				therefore this plan of correction		
	1:08 p.m., indicated the resident's diagnoses				applies to all residents of the	"	
	included, but were not limited to, major depressive				facility.		
	disorder, hypertension, stroke and legal				What measures will be put in	ito	
	blindness.				place or what systematic		
	omaness.				changes will be made to		
	Review of the record of Resident R7 on 3/28/2024				ensure that the deficient		
	at 2:00 p.m., indicated the resident's diagnoses				practice does not recur?		
	included, but were not limited to, edema,				The DON/Designee educated	that	
	hyperlipidemia, obstructive sleep apnea and atrial				pharmacist on reviewing resid		
fibrillation.				medications every 90 days on			
					3/28/24.		
	During an interview with the Nurse Consultant on				How the corrective actions w	/ill	
	03/28/24 at 12:13 p.m., indicated the Pharmacist		be monitored to ensure the				
had not been doing medication reviews for the			deficient practice will not				
assisted living residents and was unsure when the				recur? (what QA program wi	II		
last time the medications were reviewed by the		be put into place and how					
	Pharmacist.				often checked)		
					The DON/Designee will audit	5	
	The medication regi	imen review policy provided			random residents a week x 4		
	by the Nurse Consultant on 3/28/24 at 2:00 p.m.,				weeks to verify pharmacist ha	s	
	indicated the consul	ltant pharmacist would review			reviewed medications, then 3		
	the medication regin	men of each resident in			random residents weekly x 4		
sufficient detail and determine if any apparent					weeks then 3 random residen	ıts a	

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 27 of 30

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

PRINTED: 05/02/2024 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 <u>00</u>		COMPLETED		
155053		155053	B. WING		03/28/2024		
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			612 E 1			
WATERS	OF RUSHVILLE S	KILLED NURSING FACILITY, THE	<u> </u>		'ILLE, IN 46173		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	The consultant pharmacist			month x 4 months. If the facilit	-	
	• •	maceutical care consultation		within 95% compliance at the end			
	including medicatio	n regimen review monthly.			of the 6 months, the monitoring	-	
				will be stopped. At the monthly			
					QAPI meeting, the monitoring		
				be reviewed. Any concerns will			
					have been corrected as found.		
					Any patterns will be identified. If		
					necessary, an Action Plan will be		
					written by the committee. Any written Action Plan will be		
					monitored by the Administrato	r	
				weekly until resolution.	ı		
					weekly drill resolution.		
					By what date the systemic		
					changes will be completed?		
					Date of Compliance: April 29,		
					2024		
R 0300	410 IAC 16.2-5-6(
		ervices - Deficiency					
Bldg. 00	` '	ter medications, prescription					
		cals used in the facility					
		accordance with currently					
		onal principles and include					
		cessory and cautionary					
	instructions and th	е ехрігаціон часе.	R 03	00	R300 Pharmaceutical Servic	oe.	04/20/2024
	Based on observation	on, interview and record	K 03	UU	It is the policy of this facility to		04/29/2024
		failed to ensure over the			ensure that OTC medications		
	-	ications for 1 of 3 residents			labeled correctly, in the event		
		f 3 medications pass			manufacturer's directions diffe		
	observations with 2	-			from the physician's order.		
		ed medications, which included			What corrective actions will I	be	
		ed directions for use.			accomplished for those		
	(Resident R8 and Q	MA 4)			residents found to have beer	1	
	Findings include:				affected by the deficient practice? Resident R1 was assessed by	, the	
	During a medication	1 pass observation on 3-28-24			DON on DATE, an no negative		

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 28 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155053		B. WING 03/28/2024			/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				612 E 1			
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE			<u> </u>		ILLE, IN 46173		
(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
		QMA 4 for Resident R8, she			outcome related to this alleged	d	
		tain an OTC bottle of			deficient practice.		
	_	igram (mg) strength, from the			How other residents having t		
		ich indicated the bottle			potential to be affected by the		
	_	nt R1. The manufacturer's			same deficient practice will be		
		for use for this medication		identified and what corrective			
	indicated to take 1 tablet every 4 to 6 hours "while				actions will be taken?	_	
		f pain or fever does not			The DON/Designee completed an		
		2 tablets may be used. Do not			audit of the residents OTC		
		24 hours unless directed by a			medications to for appropriate		
	doctor."			labeling on 4/18/24			
					What measures will be put in	ito	
	QMA 4 was observed to obtain 2 tablets of				place or what systematic		
	ibuprofen 200 mg from the bottle, labeled as				changes will be made to		
	ibuprofen 200 mg strength. She indicated				ensure that the deficient		
	Resident R8's physician order was for ibuprofen				practice does not recur?		
	400 mg three times daily. A review of Resident				The DON/Designee in-service		
	R8's physician orders indicated he was to receive ibuprofen 400 mg three times daily by mouth, with				nursing staff 4/18/24 for labeling	-	
					OTC medications with a chang	-	
	the order date of 5-31-22. He had an additional				direction label and that the name of the resident and date opened		
	order for ibuprofen 200 mg every 4 hours as				-	ea	
	needed for pain, with the order date of 4-8-21.				must also be on the bottle/package and not sharing		
	In an intension with OMA 4 (41) (1)				medications with other residents.		
	In an interview with QMA 4 at this time, she				Any staff that fails to comply with		
	indicated she was not aware OTC medications				the points of this in-service will be		
	required any specific labeling.				further educated and/or disciplined		
	On 3-28-24 at 2:42 n m. the Corporate Marce				as indicated.		
	On 3-28-24 at 2:42 p.m., the Corporate Nurse provided a copy of a policy entitled, "Prescription				How the corrective actions w	/ill	
			be monitored to ensure the				
	Labels." This policy was identified as the current policy utilized by the facility and was dated		deficient practice will not				
	February 2017. This policy indicated,		recur? (what QA program will				
	"Medications are labeled in accordance with State				be put into place and how		
		well as facility requirements.			often checked)		
	Each prescription m				DON/Designee will audit 5 ran	ndom	
	includesDirections for use, including route of				residents weekly for 4 weeks t		
	administration"				ensure change of direction lab		
					are being used and that OTC		
	2.5-6(c)(4)				labeled correctly, then 3 rando		
					residents weekly for 4 weeks,		
			l		, , , , , , , , , , , , , , , , , , , ,		

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 29 of 30

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

PRINTED: 05/02/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155053	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2024			
NAME OF PROVIDER OR SUPPLIER WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD 612 E 11TH ST E RUSHVILLE, IN 46173					
(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		
	REGULATORY OR LSC IDENTIFYING INFORMATION			2 random residents weekly x months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will he been corrected as found. Any patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29, 2024	the pe			

State Form Event ID: NKHO11 Facility ID: 000018 If continuation sheet Page 30 of 30