STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST 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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 25, 26, 27 & 28 2024 Facility number: 000018 Provider number: 155053 AIM number: 100273930 Census Bed Type: SNF/NF: 34 Residential: 12 Total: 46 Census Payor Type: Medicare: 3 Medicaid: 27 Other: 4 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 4, 2024	F 0000	=”” p=””> Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Law. The Facility's date of alleged compliance is 4/29/2024. The Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately code Section J regarding falls for 2 of 17 residents reviewed for Minimum Data Set accuracy. (Resident 14 and Resident 16)	F 0641	F 641 Accuracy of Assessments: It is the policy of this facility to ensure accuracy of all assessments. What corrective actions will be accomplished for those residents	04/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana Gore	Administrator	04/29/2024

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	Findings include: 1. The clinical record for Resident 14 was reviewed on 3/25/2024 at 2:45 p.m. The medical diagnosis included dementia. An Annual Minimum Data Set (MDS) Assessment, dated 1/27/2024, indicated Resident 14 had one fall without injury during that review period. A nursing progress note, dated 1/13/2024, indicated that Resident 14 was found lying on her right side on her floor mat with a bruise to the right elbow. 2. The clinical record for Resident 16 was reviewed on 3/25/2024 at 2:10 p.m. The medical diagnosis included dementia. An Annual MDS Assessment, dated 9/26/2023, indicated that Resident 16 had one fall without injury during that review period. An intradisciplinary note for Resident 14, dated 8/23/2023, indicated she had a fall that resulted in head laceration requiring staples for closure. An intradisciplinary note for Resident 14, dated 9/13/2023, indicated she had slid off the bed without injury. An interview with the MDS Nurse on 03/27/24 at11:38 a.m. indicated that the facility codes MDS assessments to the Resident Assessment Instrument. After reviewing the two aforementioned assessments, she will be entering modifications of records to accurately reflect the falls.		found to have been affected by the deficient practice? Resident 14 & 16's fall assessments were modified on 3/27/2024 by the MDS nurse with no negative outcome related to this 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? All residents have the potential to be affected. All residents with falls were audited per MDS coordinator on 3/27/24 and found to be accurate. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? MDS Coordinator was educated on the accuracy of assessments by Regional MDS Nurse on 3/27/24. MDS coordinator will audit all fall assessments monthly to ensure accuracy of assessments and report any findings to the Administrator via the QAPI process. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked) MDS coordinator will audit Section	

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			J on the MDS assessments for accuracy of assessments for 10 random residents weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents weekly x 4 months. If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. By what date the systemic changes will be completed? Date of Compliance: April 29, 2024	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observations, interview, and record	F 0684	**F684 Quality of Care:** It is the policy of this facility to	04/29/2024

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	review, the facility failed to accurately monitor residents for bruising per physician order for 2 of 3 residents reviewed for bruising. Findings include: 1. The clinical record for Resident 14 was reviewed on 3/25/2024 at 2:45 p.m. The medical diagnosis included dementia. An Annual Minimum Data Set (MDS) Assessment, dated 1/27/2024, indicated Resident 14 was cognitively impaired and at risk for developing skin impairments, but did not have any alternations in skin. A bruising care plan, dated 2/6/2020, indicated to monitor skin daily during care. A physician order for Resident 14, dated 12/14/2022, indicated to monitor three times a day for chronic bruising to her bilateral arms. A physician's order for Resident, dated 1/24/2022, indicated for Resident 14 to utilize aspirin 81 milligrams (mg) every day. An observation on 3/25/2024 at 11:37 a.m. indicated she was sitting in the common area in her wheelchair. She was noted to have long sleeves that were slightly pulled up. A moderate sized bruise with a scabbed area was noted to her left forearm. Review of the treatment administration record for Resident 14 indicated that the bruising had been monitored on 3/25/2024 and the morning of 3/26/2024. The nursing progress notes did not reflect the		ensure accurate monitor residents with bruises. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 14 & 21's progress notes were updated on 3/26/24 with no negative outcome related to this alleged deficient practice by the DON. **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 on 3/26/24 of all residents requiring monitoring for skin conditions to ensure that all residents affected had adequate notes regarding their conditions for monitoring. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on policy for standards of practice relating to monitoring of skin conditions on 4/18/24, and proper documentation of all skin conditions that require monitoring per physician orders. Any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as	

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	bruised or scabbed area until 3/26/2024 at 4:05 p.m. The nursing note indicated Resident 14 had a bruise that measured 2.5 cm (centimeter) by 5.4 cm with a scabbed area measuring 0.6 cm by 0.1 cm. 2. The clinical record for Resident 21 was reviewed on 3/26/2024 at 11:14 a.m. The medical diagnosis included atrial fibrillation. A skin care plan, dated 10/11/2019, indicated to monitor Resident 21's skin daily during care. A physician's order, dated 5/31/2023, indicated that Resident 14 received blood thinning medication twice a day for atrial fibrillation. A physician's order, dated 5/17/2023, indicated to " ...Observe for Signs and Symptoms of Bleeding/Bruising every shift. Document unusual findings in progress note." During an interview and observation on 3/25/2024 at 12:03 p.m., Resident 14 was noted to have a small bruise to her left posterior hand near the thumb. She indicated she did not know how she received this bruise and that it was fading. Review of the treatment administration record for Resident 16 indicated that the bruising had been monitored on 3/25/2024 and the morning of 3/26/2024. The nursing progress notes did not reflect this bruise until 3/26/2024 at 5:36 p.m. The nursing note indicated Resident 16 had a bruise that measured 2.0 cm (centimeter) by 1.5 cm. A policy entitled, "Physician order - (Following Physician Orders)", was provided by the Regional Nurse Consultant on 3/27/2024 at 2:00 p.m. The		indicated. **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)** DON/Designee will audit documentation of skin conditions 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months in the morning clinical meeting to ensure that monitoring is being completed in accordance with standards of practice. DON/Designee will utilize the treatment record of each residents and check for a corresponding progress note to ensure monitoring is done per physician order. If the facility is within 95% compliance at the end of the months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	

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	policy indicated, "It is the policy of the facility to follow the orders of the physician ..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to implement a pressure relieving intervention as ordered by the podiatrist for a resident with an unstageable pressure ulcer (full thickness tissue loss ulcer covered by eschar) on the right heel for 1 of 2 residents reviewed for pressure ulcers (Resident 4). Finding include: During an observation and interview with Resident 4 on 3/25/24 at 1:06 p.m., indicated she had a pressure ulcer on her right heel, the physician told her on 3/21/24 when she seen him in his office. The resident indicated the physician told her to keep it off the ground. The resident	F 0686	**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 be accomplished for those residents found to have been affected by the deficient practice?** Resident 4 was provided with a boot to keep her foot off the ground on 3/27/24 by the DON with no negative outcome related to this alleged deficient practice. **How other residents having the**	04/29/2024

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	was observed to be sitting in her wheelchair with her right heel directly on the floor. During an observation on 3/26/24 at 11:05 a.m., Resident 4 was sitting in the dining room with her right heel on floor. During an observation and interview on 3/26/24 at 12:28 p.m., Resident 4 sitting in her room in wheelchair with her right heel on the floor, she indicated she had worn an off-loading boot before, but had not been offered one with this pressure ulcer on her right heel. The resident indicated she would be willing to wear one now. The resident indicated she did have some pain with pressure on the right heel pressure ulcer. During an observation on 3/26/24 at 2:11 p.m., Resident 4 was sitting in her wheelchair in dining room with right heel on the ground. During an interview the Director of Nursing (DON) on 3/26/24 at 2:23 p.m., indicated the nurse who received the order from the podiatrist should have implemented an intervention to keep Resident 4's right heel off the floor. During an observation and interview with Resident 4 on 3/26/24 at 2:27 p.m., indicated the pain in her right heel was between a 2-3 on pain scale and it was not constant, it's just enough to be annoying. The resident was pleased to know that the facility would be offering her pressure relieving boots. The resident remained in the dining room with her right heel on the floor. Review of the record of Resident 4 on 3/27/24 at 12:25 p.m., generalized osteoarthritis, soft tissue disorder, muscle weakness, venous insufficiency and congestive heart failure.		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The DON/Designee completed and audit for pressure relieving interventions on 4/18/24. Any concerns were immediately addressed. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on preventing and healing pressure ulcers on 4/18/24, with emphasis on providing pressure-relieving devices to residents that require them. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will 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 audit 4 random residents that have wounds weekly for 4 weeks, then 3 random residents weekly for 4 weeks, then 2 random residents weekly x 4 months, to ensure that residents are being offloaded from pressure and have a pressure-relieving device in place.	

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	The Quarterly Minimum Data (MDS) assessment dated, 1/21/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident was at risk of developing a pressure ulcer. The podiatrist seen the resident on 3/21/24 and observed a pressure ulcer on the right heel. The podiatrist ordered the resident to keep heel off the ground. The plan of care for Resident 4, dated 3/22/24, indicated the resident had a wound on the right heel. The interventions included, but were not limited to, (3/27/24) encourage the resident to keep the right heel off the ground per physician order and (3/27/24) encourage the resident to wear a heel boot when her heel was not elevated. The wound care note for Resident 4, dated 3/25/24, indicated the resident went to the podiatrist to get her toenails clipped, while the resident was there the physician found an unstageable pressure injury on the right heel. The area was 0.5 centimeter (cm) by 0.5 cm 100% eschar. The resident had no drainage and had pain of a 2 on the 1-10 pain scale. The physician order policy provided by the Nurse Consultant on 3/27/24 at 2:00 p.m., indicated the resident facility would follow the orders of the physician. 3.1-40(a)(2)		If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based in interview, observation, and record review, the facility failed to ensure a left-hand protector or brace was available for 1 of 1 resident reviewed for contractures. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 3/26/2024 at 2:05 p.m. The medical diagnosis included heart failure. An Annual Minimum Data Set Assessment indicated Resident 10 had moderate cognitive impairment. An interview and observation with Resident 10 on 3/25/2024 at 1:22 p.m. indicated that her left hand does hurt sometimes and her contracture to the left hand has worsened. She stated they used to use padding to her left palm about a year ago, but	F 0688	**F 688 Increase/Prevent Decrease in ROM/Mobility:** It is the policy of this facility to ensure splints or braces area available for residents with contractures. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 2's and Resident 10's doctor were notified of the missing braces on 3/26/24 and ordered that facility could use a rolled up washcloth or facility carrot until brace could be replaced. New braces were ordered on 3/28/24. **How other residents having the potential to be affected by the**	04/29/2024

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	the staff "gave up on using it after it was lost. She was open to trying to utilize something to her left hand for her contractures. She stated there is nothing in her room they used for her hand, and nothing was visible on the surfaces like a hand brace or palm protector. An interview and observation with Resident 2 on 3/26/2024 at 1:00 p.m. indicated that no one placed anything in her hand last night and no brace or palm protector was visible in her room. A physician's order, dated 2/22/2023, indicated for Resident 2 to utilize a left-hand protector at night rime to improve left hand range of motion. Thie order was placed on hold on 3/26/2024. An interview with the Regional Nurse Consultant on 3/27/2024 at 1:20 p.m. indicated that she was unable to find the protector for Resident 2's hand in her room, so she received an order from the physician to place it on hold and utilize a rolled washcloth or therapy carrot. A policy entitled, "Physician order - (Following Physician Orders)", was provided by the Regional Nurse Consultant on 3/27/2024 at 2:00 p.m. The policy indicated, "It is the policy of the facility to follow the orders of the physician ..." 3.1-42(a)(2)		**same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. The DON/Designee completed audit all braces worn by residents to ensure that they are available and is in use by residents per their physician orders. This audit was completed on 4/18/24. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on following physician orders for all braces/splints and reporting when splint or brace is not available on 4/18/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how 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	

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			stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to ensure the fall mat was in place for a resident while in bed for 1 of 3 residents reviewed for falls. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 3/26/2024 at 11:00 a.m. The medical diagnosis included dementia.	F 0689	**F 689 Free of Accident Hazards Supervision Devices:** It is the policy of this facility to ensure fall mats are in place while residents are in bed. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 7's fall mat was placed	04/29/2024

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	A Quarterly Minimum Data Set Assessment, dated 2/15/2024, indicated that Resident 7 was cognitively impaired. A nursing assessment, dated 3/22/2024, indicated that Resident 7 was at high risk for falls. A physician order, dated 1/3/2023, indicated for Resident 7 to " ...have a mat on the floor by her bed, while she is in it ...." An observation on 3/25/2024 at 11:46 a.m., indicated Resident 7 was laying in her bed at this time with her fall mat folded in three and stored between the foot of her bed and closet. An observation on 3/25/2024 at 1:20 p.m., indicated Resident 7 was laying in her bed at this time with her fall mat folded in three and stored between the foot of her bed and closet. She had a bottled drink in her hand at this time. An observation and interview with CNA 2 on 3/26/2024 at 1:20 p.m. indicated Resident 7 should have a fall mat in place and Resident 7 was observed with her fall mat in place. An interview with the Regional Nurse Consultant on 3/27/2024 at 1:25 p.m. indicated that nursing staff are responsible for ensuring the use of fall interventions. A policy entitled, "Guidelines for Incidents/Accidents/Falls", was provided by the Administrator on 3/27/2024 at 10:30 a.m. The policy indicated, " ...Based on the results of incident/accidents/fall, the resident's care plan will be addressed to ensure that any needed point of focus have measurable goals with appropriate		on 3/27/24 by the DON with no negative outcome related to this 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?** All residents have the potential to be affected. The DON/Designee completed an audit on 3/27/24 of all residents with fall/injury prevention mats. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on 4/18/24 on the importance of ensuring fall mats are in place when ordered. Any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will 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 audit 5 random residents to ensure placement of fall mats for 4 weeks, then 3 random residents a week x 4 weeks, then 3 random residents a month x 4 months. . If the facility is within 95% compliance at the end of the 6 months, the	

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	interventions in place ..." 3.1-45(a)(2)		monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the			

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	health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to timely enter a resident with a significant weight loss into the Skin and Weight Assessment Team (SWAT) program for 1 of 3 residents reviewed for significant weight loss. Findings include: The clinical record for Resident 14 was reviewed on 3/25/2024 at 2:45 p.m. The medical diagnosis included abnormal weight loss. Weights for Resident 14 were record as: 2/1/2024 - 99.8 lbs. (pounds) 3/1/2024 - 94.3 lbs. (-5.51% from 2/1/2024) 3/2/2024 - 92.1 lbs. (-7.72% from 2/1/2024) A SWAT note, dated 3/21/2024, indicated new interventions of including a power pudding to the lunch tray for Resident 14. An interview with the Regional Nurse Consultant on 3/27/2024 at 1:20 p.m. indicated that no SWAT notes were found for Resident 14 between 3/1/2024 and 3/21/2024. A policy entitled, "SWAT PROGRAM (SKIN AND WEIGHT ASSESSMENT TEAM)" was provided by the Regional Nurse Consultant on 3/26/2024 at 10:55 a.m. The policy indicated, " ...It is the policy of this facility to assess the nutritional status of each resident ...These residents will be monitored through this team improvement of the resident's nutritional status". Indicators to determine implementation of the SWAT monitoring for a resident would include, " ...5% or more weight change (undesirable) in 30 days ..." and that the SWAT will " ...meet weekly	F 0692	**F692 Nutrition/Hydration Status Maintenance:** It is the policy of this facility to ensure proper nutrition and hydration for all residents. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 14 was added to the SWAT program 3/27/2024, with interventions added to her care plan. Resident 14 reviewed by registered dietician and recommendations to be followed 4/25/24. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. The DON/Designee completed an audit on 3/27/24 of all residents to determine weight losses and ensure that all residents are being reviewed by the SWAT team for significant changes in weight. The DON/Designee will ensure that all recommendations of the SWAT team are addressed and implemented into the resident's plan of care. **What measures will be put into place or what systematic changes will be made to ensure that the deficient**	04/29/2024

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	to discuss residents in need of addressing currant health problems to determine appropriate interventions ..." 3.1-46(a)(1)		**practice does not recur?** The DON/Designee in-serviced the nursing staff on the SWAT team policy on 4/18/24, and the importance of reviewing and implementing interventions to address weight loss. **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)** DON/Designee will monitor residents daily in the morning clinical meeting for weight changes and referred to SWAT 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. DON/Designee will ensure that all recommendations per SWAT team, will be implemented into the resident's plan of care. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. After six months of at least 95% compliance, monitoring can be stopped, but daily monitoring of weights will continue on an on-going basis. **By what date the systemic**	

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			changes will be completed? Date of Compliance: April 29, 2024	
F 0710 SS=D Bldg. 00	483.30(a)(1)(2) Resident's Care Supervised by a Physician §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. Based on interview and record review, the facility failed to timely inform Resident 14's provider of a significant weight change for 1 of 3 residents reviewed for nutritional needs. Findings include: The clinical record for Resident 14 was reviewed on 3/25/2024 at 2:45 p.m. The medical diagnosis included abnormal weight loss. Weights for Resident 14 were record as: 2/1/2024 - 99.8 lbs. (pounds) 3/1/2024 - 94.3 lbs. (-5.51% from 2/1/2024)	F 0710	**F 710 Residents Care Supervised by Physician:** It is the policy of this facility to ensure that all residents' care is supervised by a physician. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 14's physician was notified of her weight loss on 3/28/24 resident was referred to our SWAT (skin and weight) program by the DON.	04/29/2024

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	3/2/2024 - 92.1 lbs. (-7.72% from 2/1/2024) An intradisciplinary note from 3/21/2024, that addressed Resident 14's weight loss, did not indicate the physicians was notified of the weight loss. An interview with the Regional Nurse Consultant on 3/27/2024 at 1:20 p.m. indicated she could not locate in the medical record where the attending physician was notified of the significant weight loss for Resident 14.		**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 on all residents experiencing significant weight changes on 4/1/24 and verified they had an appropriate physician notification. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff on SWAT policy and notification of physician for all significant weight losses and/or gains. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will 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 audit significant weight changes weekly via SWAT program and ensure physician notification has been made and documented on all changes x 6 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the	

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			monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure eight hours of consecutive RN coverage for 9 of 91 days reviewed. This deficient practice had the potential to affect 34 residents. Findings include:	F 0727	**F 727 RN Coverage:** It is the policy of this facility to ensure a registered nurse is available for 8 hours a day, 7 days a week. **What corrective actions will be accomplished for those**	04/29/2024

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	The PBJ (Payroll Based Journal) Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 1 2024 (October 1 - December 31) reviewed on 3/25/2024 at 1:45 p.m. indicated that nine days were noted without eight hours of consecutive RN coverage. An interview on 3/26/24 at 1:34 p.m. with Corporate Payroll indicated that he did not report any RN coverage for those aforementioned nine days due to no RN being on the skilled nursing facility. 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.		**residents found to have been affected by the deficient practice?** No residents were identified for this 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?** All residents have the potential to be affected by this cited practice, therefore, this plan of correction applies to all residents of the facility. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** **The Administrator educated the facility Nurse Administration Team (DON, ADON, and 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 reviewed, during morning meeting, 5 times per week x 4 weeks, weekly x 4 weeks then**	

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			monthly x 4 months, ensure RN coverage is conducted 7 days each week (8 consecutive hours) If the facility is within 100% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited			

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	to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based in interview and record review, the facility failed to ensure that a pharmacy recommendation was completed in a timely manner for 1 of 5 residents reviewed for pharmacy services. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 3/26/2024 at 2:05 p.m. The medical diagnosis included heart failure.	F 0756	**F 756 Drug Regimen Review:** It is the policy of this facility to ensure that all pharmacy recommendations are follow up on in a timely manner. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 2's drug regimen was reviewed and recommendation	04/29/2024

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	An Annual Minimum Data Set Assessment indicated Resident 10 had moderate cognitive impairment. A pharmacy recommendation, printed on 10/15/2023, contained a recommendation regarding a gradual dose reduction of Resident 2's antidepressant. This recommendation was not signed by a practitioner until 12/14/2023 agreeing with the reduction in her antidepressant. A correlating physician order to reflect the reduction in Resident 2's antidepressant was entered in the medical record on 12/19/2023. An interview with the Regional Nurse Consultant on 3/27/2024 at 2:20 p.m. indicated she had no further information to provide regarding the pharmacy recommendation. A policy entitled, "Policy and Procedure-Pharmacy Recommendations", was provided by the Regional Nurse Consultant on 3/26/2024 at 1:45 p.m. The policy indicated, " ...A response as to the action to be taken regarding the Pharmacy Consultant's recommendation will be documented within 7 days of the receipt of the recommendation ..." 3.1-25(i)		were initiated on 12/14/24 with no negative outcome from this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The DON/Designee will review all pharmacy recommendations for the last 90 and an concerns will be addressed by the physician. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON was in-serviced on 3/27/24 by Regional Nurse Consultant that all pharmacy recommendations will be reviewed by the DON/Designee and document the physician response within 7 days of the receipt. Additionally, any staff that Fail 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? (what QA program will be put into place and how often checked)** The DON/Designee will monitor the pharmacy recommendations upon receipt and ensure that the recommendations are acted upon by the physician within 7 days of receipt x 6 months. If the facility	

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			is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 25, 26, 27 & 28 2024 Facility number: 000018 Residential Census: 12 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 4, 2024	R 0000	=”” p=””> Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Law. The Facility's date of alleged compliance is 4/29/2024. The Facility is respectfully requesting paper compliance for all	

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			deficiencies in this POC.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) obtained a pre-authorization from a licensed nurse prior to administering an "as needed, or PRN" medication to a resident. (Resident R1) Findings include: The clinical record of Resident R1 was reviewed on 3-28-24 at 11:11 a.m. It indicated she had received a dose of oxycodone, a narcotic, on 2-8-24 at 11:30 a.m., from QMA 4. The medication administration record (MAR) documented a physician's order for this medication indicated the order was received on 12-6-23, for oxycodone 5 milligrams (mg) for 1 tablet every 8 hours as needed for pain. There was no other documentation located in the MAR or the progress notes to indicate a licensed nurse had given approval prior to the medication being administered to Resident R1. In an interview on 3-28-24 at 12:20 p.m., with QMA	R 0246	**R 246 Health Services:** It is the policy of this facility to ensure health services to our assisted living residents. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident R1 was assessed by the DON on 3/28/14 and had no negative outcome related to this 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?** All residents have the potential to be affected by this cited practice, therefore, this plan of correction applied to all residents of the facility. **What measures will be put into place or what systematic**	04/29/2024

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	155053	A. BUILDING 00 B. WING	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

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	4, she indicated if a QMA administers a PRN medication, the QMA is to check with one of the licensed nurses of the facility before the medication is administered and to place a notation in the progress note about which nurse provided the prior authorization. In an interview on 3-28-24 at 12:35 p.m., with the Regional Nurse Consultant, she indicated she 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 R1. In an interview on 3-28-24 at 2:30 p.m., with the Regional Nurse Consultant, she indicated the facility does not have a particular policy or procedure related to QMA's administering PRN medications. She indicated the facility utilizes the State's scope of practice. The Indiana Department of Health's Long-Term Care Division's Residential Regulations, 410 IAC 16.2-5 (2008) at 410 IAC 16.2-5-4(e)(6) references this information as follows, "PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration for each of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRN's shall be documented in the nursing notes indicated the time and date of the contact." 2.5-1.4(e)(6)		**changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nurses and QMA's that prior approval by the nurse is required for a QMA to give a PRN medication on 4/18/24. The nurse must document in the progress notes that approval was granted to give the medication or nurse must sign off with the QMA on the Medication Administration record. Staff 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? (what QA program will be put into place and how often checked)** DON/Designee will monitor the QMA's medication administration record daily in the morning clinical meeting for PRN medication administration five times a week x 4 weeks, then 3 times a week x 4 weeks, the once a week x 4 months.. DON/Designee will check for a corresponding progress note or sign off on the MAR by the nurse, if PRN medication was administered. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be	

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			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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review the facility failed to have pharmacy review residents' medication every 90 days for 4 of 7 residents reviewed for pharmacy services (Resident R1, R3, R6 and R7). This had the potential to affect 8 of 14 residents which the facility stored and	R 0298	**R298 Pharmaceutical Services:** It is the policy of this facility to ensure prescription narcotics are not administered to a resident without am appropriate prescription. **What corrective actions will be**	04/29/2024

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	administered medications to. Finding include: Review of the record of Resident R1 on 3/28/24 at 11:11 a.m., indicated the resident's diagnoses included, but were not limited to , hypertension, major depressive disorder, hemiplegia, anxiety disorder and edema. Review of the record of Resident R3 on 3/28/24 at 12:55 p.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder, hypoxia, hypertension, lung cancer and malnutrition. Review of the record of Resident R6 on 3/28/24 at 1:08 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, hypertension, stroke and legal blindness. Review of the record of Resident R7 on 3/28/2024 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, edema, hyperlipidemia, obstructive sleep apnea and atrial fibrillation. During an interview with the Nurse Consultant on 03/28/24 at 12:13 p.m., indicated the Pharmacist had not been doing medication reviews for the assisted living residents and was unsure when the last time the medications were reviewed by the Pharmacist. The medication regimen review policy provided by the Nurse Consultant on 3/28/24 at 2:00 p.m., indicated the consultant pharmacist would review the medication regimen of each resident in sufficient detail and determine if any apparent		**accomplished for those residents found to have been affected by the deficient practice?** Resident R1, R3, R6 and R7 were referred to Pharmacy Consultant for review on 3/28/24 with no negative outcome related to this 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?** All residents have the potential to be affected by the cited practice, therefore this plan of correction applies to all residents of the facility. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee educated that pharmacist on reviewing residents medications every 90 days on 3/28/24. **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 DON/Designee will audit 5 random residents a week x 4 weeks to verify pharmacist has reviewed medications, then 3 random residents weekly x 4 weeks then 3 random residents a	

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	irregularities exist. The consultant pharmacist would provide pharmaceutical care consultation including medication regimen review monthly.		month x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to ensure over the counter (OTC) medications for 1 of 3 residents observed during 1 of 3 medications pass observations with 2 staff members, had appropriately labeled medications, which included the physician-ordered directions for use. (Resident R8 and QMA 4) Findings include: During a medication pass observation on 3-28-24	R 0300	**R300 Pharmaceutical Services:** It is the policy of this facility to ensure that OTC medications are labeled correctly, in the event the manufacturer's directions differ from the physician's order. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident R1 was assessed by the DON on DATE, an no negative	04/29/2024

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	at 11:20 a.m., with QMA 4 for Resident R8, she was observed to obtain an OTC bottle of ibuprofen, 200 milligram (mg) strength, from the medication cart, which indicated the bottle belonged to Resident R1. The manufacturer's label for directions for use for this medication indicated to take 1 tablet every 4 to 6 hours "while symptoms persist. If pain or fever does not respond to 1 tablet, 2 tablets may be used. Do not exceed 6 tablets in 24 hours unless directed by a doctor." QMA 4 was observed to obtain 2 tablets of ibuprofen 200 mg from the bottle, labeled as ibuprofen 200 mg strength. She indicated Resident R8's physician order was for ibuprofen 400 mg three times daily. A review of Resident R8's physician orders indicated he was to receive ibuprofen 400 mg three times daily by mouth, with the order date of 5-31-22. He had an additional order for ibuprofen 200 mg every 4 hours as needed for pain, with the order date of 4-8-21. In an interview with QMA 4 at this time, she indicated she was not aware OTC medications required any specific labeling. On 3-28-24 at 2:42 p.m., the Corporate Nurse provided a copy of a policy entitled, "Prescription Labels." This policy was identified as the current policy utilized by the facility and was dated February 2017. This policy indicated, "Medications are labeled in accordance with State and Federal laws as well as facility requirements. Each prescription medication label includes...Directions for use, including route of administration..." 2.5-6(c)(4)		outcome related to this 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 the residents OTC medications to for appropriate labeling on 4/18/24 **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The DON/Designee in-serviced the nursing staff 4/18/24 for labeling OTC medications with a change of direction label and that the name of the resident and date opened must also be on the bottle/package and not sharing medications with other residents. Any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will 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 audit 5 random residents weekly for 4 weeks to ensure change of direction labels are being used and that OTC are labeled correctly, then 3 random residents weekly for 4 weeks, then	

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			2 random residents weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution. **By what date the systemic changes will be completed?** Date of Compliance: April 29, 2024	