STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PERU SKILLED NURSING FACILITY, THE	317 BLAIR PIKE PERU, IN 46970

(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. Survey dates: August 21, 22, 23, 24, & 25, 2023 Facility number: 000014 Provider number: 155039 AIM number: 100288670 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 1 Medicaid: 26 Other: 8 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/29/23.	F 0000	**September 7, 2023 Indiana State Department of HealthAttn: Brenda Buroker, Director of Long Term Care2 North Meridian StreetIndianapolis, In 46204 RE: Survey Event ID NQN911 Dear Ms. Buroker, Please accept the enclosed plan of correction as a credible allegation of compliance to the deficiencies cited during our Recertification and State Licensure Survey conducted on Aug 25, 2023 at Water's of Peru. Our latest date of compliance will be September 11, 2023. Hopefully you will find that our remedies are sufficient. Water's of Peru is respectfully requesting paper compliance. If after reviewing our plan of correction, you have questions or require further information, please do not hesitate to call me at your convenience at 765-473-4426 Sincerely, Debra Coppernoll, HFAAdministrator**	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie L Coppernoll	Administrator	09/07/2023

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

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	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 observation, record review and interview, the facility failed to follow Physician orders for administration of a pain medication and the use of palm protectors and offloading boots for 2 of 19 residents whose physician orders were reviewed. (Resident 5 & 11) Findings include: 1. During a medication observation on 8/23/2023 at 4:07 A.M., RN 4 was observed to administer a Percocet (narcotic pain medication) to Resident 5. A record review was completed on 8/23/2023 at 4:25 A.M. Resident 5's diagnoses included, but were not limited to: anxiety, depression, hypertension, pain and insomnia. Resident 5's physician orders included: Oxycodone- Acetaminophen 5/325 mg (milligram). Give 1 tablet by mouth every 4 hours as needed for severe pain (pain related 4-7 on the scale) maximum of 6 doses daily. The Medication Administration Record (MAR), dated August 2023, indicated Resident 5 had received the narcotic pain medication for a pain level of 3 on 8/23/2023 and had received it 14 other times for pain levels of 0 to 3. During an interview, on 8/23/2023 at 4:48 A.M., RN 4 indicated he should not have given the medication to her and he did not follow the physician orders.	F 0684	**It is the policy of The Waters of Peru to follow all physician orders as they are written. Any clarification is to be addressed with the Physician themselves.** · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Two residents were affected by this deficient practice. Resident #5 had a physician order for Oxycodone/Acetaminophen 5/325 every 4 hours as needed for a pain related scale of 4-7. Resident #5 received the PRN Oxycodone/Acetaminophen 5/325 without the proper pain related scale being followed. Resident #11 had a physician order for a palm shield for each hand and a heel lift device on right foot to be worn at all times. It was found that resident was not wearing her Palm shield devices nor was she wearing her heel lift device. Resident #5 and Resident #11 were assessed with no negative outcomes. To ensure this deficient practice	09/11/2023

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	2. During an observation, on 8/21/2023 at 10:35 A.M., Resident 11 was observed without a palm shield on either hand or a heel lift device on right foot. During an observation, on 8/22/2023 at 1:43 P.M., Resident 11 was observed not wearing a palm shield on either hand or a heel lift device on right foot. During an observation, on 8/23/2023 at 1:45 P.M., Resident 11 was observed not wearing a palm shield on either hand or a heel lift device on right foot. A record review was completed on 8/24/2023 at 8:55 A.M. Resident 11's diagnoses included, but were not limited to: traumatic brain dysfunction, non-Alzheimer's dementia, diabetes mellites, anxiety disorder, depression, and psychotic disorder. A Physician's order, dated 7/12/2022, indicated palm shield should be worn on both hands while in bed. A Physician's order, dated 3/28/2023, indicated a heel lift device for lower right extremity should be worn at all times. An August 2023 Treatment Administration Record (TAR) indicated Resident 11 was wearing a palm shield on both hands and wearing a heel lift device on lower right extremity on 8/21/2023, 8/22/2023, and 8/23/2023. During an interview, on 8/25/2023 at 9:02 A.M., LPN 10 indicated the TAR is used to document the use of Resident 11's palm shields and heel lift device, and if the resident refused to wear the		does not occur again staff will be educated by on the importance of following physician orders along with staff will be monitored to ensure that physician orders are being followed properly. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who take pain medication or/and have adaptive devices have the potential to be affected by this deficient practice. All Staff will be educated on the importance of ensuring Physician orders will be followed along with Staff will be monitored to ensure that physician orders are being followed. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; To ensure this deficient practice does not recur all staff will be educated on the importance of following physician orders. Education was provided by Staff Development Director Georgia McQuinn on 9/6/23. Any staff that fails to comply with the points of this in-service will be further	

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	palm shields or heel lift device, the treatment should be documented as refused on the TAR. During an interview, on 8/25/2023 at 9:14 A.M., the Director of Nursing indicated Resident 11 should have been wearing the heel lift device and a palm shield on both hands while in bed on 8/21/2023, 8/22/2023, and 8/23/2023. The DON indicated the TAR has an option for staff to code refused when a resident refuses a treatment, and that the heel lift device and palm shield entries on Resident 11's TAR for 8/21/2023, 8/22/2023, and 8/23/2023 were charted incorrectly and should have been charted correctly. An undated policy titled " Physician Orders (Following physician orders)" was provided by the Administrator on 8/23/2023 at 11:03 A.M. and identified as current. The policy indicated, "It is the policy of the facility to follow the orders of the physician ....". 3.1-37(a)		educated/disciplined as indicated. · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Director of Nursing/Designee will complete the QA tool titled Following Physician Orders (Attachment A). This tool will be completed daily (M-F) auditing 10 random residents receiving pain medication and assistive devices weekly for 4 weeks, then 5 random residents weekly for 4 weeks, then 3 random residents weekly for 4 months. If facility is 95% compliant after 6 months the monitoring will stop. Any concerns will be addressed immediately and have a Quality Assurance and Quality improvement action plan completed. **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The**	

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			facility will need to submit an amended plan of correction with the updated plan of correction date. All systemic changes will be completed by 9/11/2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen concentrators were clean and free from dust for 2 of 2 residents who were reviewed for oxygen use. (Resident 11 & 13) Findings include: 1. During an observation, on 8/21/2023 at 10:24 A.M., Resident 11's oxygen concentrator's vent was covered with dust. During an observation, on 8/23/2023 at 8:57 A.M., Resident 11's oxygen concentrator's vent was covered with dust. During an observation, on 8/24/2023 at 10:30 A.M., Resident 11's oxygen concentrator's vent was covered with dust.	F 0695	It is the policy of The Waters of Peru to keep oxygen concentrators free from dust. · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Two residents were affected by this deficient practice. It was found that Resident #11 and Resident 13's Oxygen vent was covered in dust. Resident #11 and #13 concentrator and filters were cleaned. DON did an audit of all residents receiving oxygen and filters and concentrators were	09/11/2023

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	During an observation, on 8/25/2023 at 9:39 A.M., Resident 11's concentrator vent covered with a large amount of dust. A record review was completed on 8/25/2023 at 10:01 A.M. Resident 11's diagnoses included, but were not limited to: dementia, diabetes, dysphagia, gastroenteritis, depression, and acute and chronic respiratory failure. Resident 11's current physician orders included: O2: Change oxygen tubing and humidifier and clean concentrator filter weekly every night shift every Sunday. The Treatment Administration Record (TAR), dated August 2023, indicated the concentrator filter had been cleaned on 8/20/2023. During an interview, on 8/25/2023 at 9:40 A.M., the Director of Nursing (DON) indicated the filter was not cleaned and should have been. She indicated that companies will come in and clean their own machines. 2. During an observation, on 8/25/2023 at 9:39 A.M., Resident 13's oxygen concentrator vent was covered with a large amount of dust. A record review was completed on 8/25/2023 at 10:01 A.M. Resident 13's diagnoses included, but were not limited to: dementia, diabetes, delusional disorder, hallucinations, and hypertension. Resident 13's current physician orders included; O2: Change oxygen tubing and humidifier. (concentrator filter cleaned yearly by [name of company] every night shift every Sunday.		cleaned on 8/25/2023. To ensure this deficient practice does not occur staff will be educated on the importance of ensuring the Oxygen concentrator is free from dust and cleaned properly. The Waters of Peru also has some concentrators that the filter is cleaned annually by our Oxygen Company – SMS. SMS will be called to come in and clean the concentrator filters. This will then be properly documented and tracked to ensure the concentrator filters are being cleaned properly by SMS. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who use oxygen have the potential to be affected by this deficient practice. DON did an audit of all residents receiving oxygen and filters and concentrators were cleaned on 8/25/2023. Staff will be educated on the importance of ensuring all concentrator vents/filters are cleaned properly. The Waters of Peru also has some concentrators that the filter is cleaned annually by our Oxygen Company – SMS. SMS will be called to come in and	

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	During an interview, on 8/25/2023 at the 9:40 A.M., the DON indicated the filter was not cleaned and should have been. She indicated the last time the filter was cleaned was sometime in 2022. On 8/25/2023 the DON provided the policy titled, "Oxygen Administration Protocol", dated 10/25/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...B. Concentrators wipe clean with mild soap and sterile or distilled water as needed. If the concentrator has a visible filter on the back of machine, it must be removed weekly and rinsed with sterile or distilled water until clean, pat dried and replaced. Document filter cleaning on treatment sheet. [Name of Company] will clean all internal filters on concentrators with no visible filter...." 3.1-47(a)(6)		clean the concentrator filters. This will then be properly documented and tracked to ensure the concentrator filters are being cleaned properly by SMS. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Staff development Director Georgia McQuinn educated staff on 9/6/2023 on the importance of cleaning concentrator filters properly. Staff will document when the concentrator filter has been cleaned. The Waters of Peru also has some concentrators that the filter is cleaned annually by our Oxygen Company – SMS. SMS will be called to come in and clean the concentrator filters. This will then be properly documented and tracked to ensure the concentrator filters are being cleaned properly by SMS. Any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. · **how the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place; and Director of Nursing/Designee will complete the QA tool titled Following Oxygen Concentrator Vent/Filter dust free (Attachment A). This tool will be completed weekly X 6 months. If the facility is 95% compliant after 6 months audits will be stopped. Any concerns will be addressed immediately and have a Quality Assurance and Quality improvement action plan completed. **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** All systemic changes will be complete on 9/11/2023	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 5 of 18 rooms toured and 1 of 2 lounge areas reviewed for environment, related to wainscoting falling off the wall, peeling paint, unpainted spackle in resident's rooms, and an unattached electrical outlet in lounge area. (Room 38, Room 61, Room 23, Room 34, Room 59, Boulevard Unit) Findings include: During a tour with the Director of Maintenance, (DM) on 8/25/2023 at 10:22 A.M., the following was observed: Room 38-2 had wainscoting falling off the wall behind bed. Room 61-2 had bubbling and peeling paint above the air conditioner unit. Room 23, 34, and 59 had unpainted spackle areas on the walls. The Boulevard Unit had an outlet not attached to the wall in a lounge room. During an interview, on 8/25/2023 at 10:35 A.M., the Director of Maintenance indicated he was not aware of the wainscoting falling off the wall in room 38-2, bubbling and peeling paint above the air conditioner unit, or an outlet not attached to the wall in a lounge area on the Boulevard Unit. For the unpainted spackle in rooms 23, 34, and 59, DM indicated that spackle needs to dry for 24 hours before it can be sanded down and	F 0921	**It is the policy of the Waters of Peru to provide a safe/functional/sanitary and comfortable environment for our residents.** · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Five residents were affected by this deficient practice. It was found that room 38 – 2 had wainscoting falling off the wall behind the bed. Room 61-2 had bubbling and peeling paint above the air conditioner, and rooms 23, 34, and 59 had unpainted spackle on the wall. And the boulevard unit had an outlet not attached to the wall in the lounge. Wainscoting was repaired, the bubbling and peeling paint were cleaned up and repainted, all rooms with spackle were painted appropriately and the outlet was reattached to the wall. Maintenance will be educated on the importance of ensuring resident rooms are safe/functional and sanitary. · **how other residents having the potential to be**	09/11/2023

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	determined if it can be painted or if more spackle is needed. Painting spackle generally gets done within a week, but it depends on the urgency of other work orders. When asked how work is prioritized, DM indicated work is prioritize by importance. For example, resident safety comes first, then broken AC/heater, pipes, etc. DM indicated he is the only employee in the maintenance department. DM indicated he tours the facility daily, inspects lights, exit doors, and spot checks resident rooms. Each resident room is toured by maintenance monthly. On 8/25/2023 at 10:37 A.M., a policy was requested for preventative maintenance, but one was not provided. On 8/25/2023 at 10:42 A.M., The DM provided a document titled "Monthly Preventative Maintenance Report" and indicated that it is currently being used by the facility. HVAC Compressor Operational and Wallpaper/Paint not marked, are listed as monthly checks on the "Monthly Preventative Maintenance Report". 3.1-19(f)		**affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. Staff will be educated on the importance of ensuring to make sure maintenance is aware of any underlying issues in patient rooms. Maintenance director did an audit of all rooms and corrected any other items that needed repair. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director educated All staff on 9/6/2023 on how to fill out maintenance forms and ensure they give a copy to the administrator when they should find any maintenance issues in resident rooms. Maintenance staff were educated by the administrator on 8/25/23 on ensuring all resident rooms are safe/functional/sanitary and comfortable. Maintenance will round daily to ensure that all rooms are safe/functional/sanitary and comfortable. Any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.	

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			· **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Maintenance Director/Designee will complete the QA tool titled (Attachment A) safe/functional/sanitary and comfortable. Maintenance director will audit of 10 random rooms a week for 4 weeks, then 5 random rooms a week for 4 weeks, 5 random rooms monthly X 4 months. If the facility is 95% compliant after six months the monitoring will stop. Any concerns will be addressed immediately and have a Quality Assurance and Quality improvement action plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the**	