STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00449003, IN00450004, IN00451940, IN00454556, and IN00455065. Complaint IN00449003 - No deficiencies related to the allegations are cited. Complaint IN00450004 - No deficiencies related to the allegations are cited. Complaint IN00451940 - No deficiencies related to the allegations are cited. Complaint IN00454556 - No deficiencies related to the allegations are cited. Complaint IN00455065 - Federal/state deficiencies related to the allegations are cited at F0849. Survey dates: March 10 & 11, 2025 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 44 Total: 44 Census Payor Type: Medicare: 1 Medicaid: 37 Other: 6 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Smith	RDO	03/25/2025

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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	Quality review completed March 17, 2025.			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services Based on record review and interview, the facility failed to review and implement the hospice provider's plan of care resulting in a resident receiving Cardiopulmonary Resuscitation efforts for a resident who had signed a Do Not Resuscitate Directive for 1 of 3 resident reviewed for death. (Resident E) Findings include: Resident E's closed clinical record was reviewed on 3/10/25 at 11:48 a.m. Diagnoses included nontraumatic intracerebral hemorrhage/stroke, muscle wasting and atrophy, and dysphagia. The resident was admitted to hospice services on 10/24/24 at 6:59 p.m. A signed physician's order, dated 9/25/24, indicated the resident was a Full Code (CPR was to be initiated as appropriate). A signed physician's order, dated 10/22/24, indicated hospice was to evaluate and treat. A health care plan, dated 9/25/24, indicated the resident had elected a Full Code status. The care plan and interventions had no review or revised dates. A health care plan, dated 10/25/24, indicated the resident received hospice services. The goal indicated the resident's wishes for hospice services would be respected. Interventions included hospice services as order.	F 0849	F849 – Hospice Services It is the policy of this facility to ensure the plan of care for each resident on hospice is implemented and communicated between the facility and hospice provider. 1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident E no longer resides in the facility. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. DON/Designee audited all hospice binders for accurate code status documentation on 3.12.25 with no other residents being affected by the alleged deficient practice. SSD/Designee completed care plans with all current hospice companies on providing documentation of communication for each visit including any changes of code status on 3.21.25 3 What measures will	03/26/2025

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	A review of the resident's hospice documentation on 3/10/25 at 11:48 a.m., indicated the plan of care and hospice certification form were completed 10/24/25. The plan of care indicated the resident's advanced directive/code status as do not resuscitate. An email sent to the facility Administrator, dated 10/25/24 at 10:29 a.m., provided by the hospice provider, included a POST (Physician Orders for Scope of Treatment) form attachment. The form indicated "Do Not Attempt Resuscitation/DNR" as the resident's code status. A nursing progress note, dated 12/17/24 at 8:15 a.m., indicated LPN 4 had entered the resident's room to delivery her breakfast tray. She observed the resident was not responding to verbal or tactile stimuli. She immediately left the room and checked the resident's code status in the electronic health record. The resident's clinical record indicated the resident was a full code. LPN 4 called for staff assistance and initiated cardiopulmonary resuscitation (CPR). A nursing progress note, dated 12/17/24 at 8:20 a.m., indicated Emergency Medical Technicians, Paramedics and the Fire Department arrived and took over resuscitation efforts. A nursing progress note, dated 12/17/24 at 8:40 a.m., indicated cardiopulmonary resuscitation was discontinued and the resident was declared deceased. During an interview on 3/10/25 at 3:39 p.m., LPN 4 indicated, when she entered Resident E's room (on 12/17/24), she observed the resident positioned on her back with her head facing the window. She		be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The RDO/Designee educated the SSD and nursing managers on obtaining accurate code status documentation for hospice residents and obtaining POST forms from hospice providers on 3.12.25. Additionally, any staff members that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will complete an audit on hospice communication documentation, ensuring code status is accurate, 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action	

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	noticed her skin color was more pale than her usual. Her skin was cool to the touch. She was not familiar with the resident and checked her code status and noted she was a full code. She began chest compressions and alerted staff. She was aware the resident was admitted to hospice, but she had known hospice residents to be a full code before. Other staff mentioned they believed the resident was a DNR and it had been discussed previously in October. All the information she observed in the resident's electronic health record indicated the resident was a full code, so she continued CPR until another staff member took over. During an interview on 3/11/25 at 9:31 a.m., SSD indicated she received a call from the MDS Coordinator on 12/17/24 requesting any clarification on the resident's code status. She indicated she had no clarification and would need to look it up when she arrived at the facility. She called the hospice provider when she arrived at the facility and was able to obtain a faxed copy of the resident's POST form indicating the resident was a DNR. She indicated she had not reviewed the resident's hospice admission paperwork or plan of care. She should have reviewed the documentation in order to coordinate the resident's plan of care with the facilities plan of care. She felt the lack of review of the hospice clinical documentation lead to the confusion and the resident receiving CPR. During an interview on 3/11/25 at 10:22 a.m., the MDS Coordinator indicated compressions had already begun when she arrived at the resident's room. She had called the SSD to clarify the resident's code status when the resident was receiving hospice services. The SSD called the hospice provider when she arrived at the facility		Plan will be monitored by the Administrator weekly until resolution. 5 By what date the systemic changes for each deficiency will be completed. Corrective action completion date: 3.26.25.	

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	and the provider indicated they had a DNR on file. The EMS personnel discontinued CPR when the POST form, faxed by the hospice provider, was received. During a telephone interview on 3/11/25 at 3:38 p.m., the Director of Health Hospice indicated an electronic copy of the POST form and admission documentation was emailed to the facility administrator on 10/25/24. A current facility policy, dated 10/9/24, titled, "Guidelines for Palliative Care-Hospice Care," provided by the Administrator on 3/11/25 at 3:21 p.m., included the following: "..Key Elements of Maintain Compliance regarding Hospice...4) There must be a designated member of the facility's IDT (Interdisciplinary Team) who is responsible for working with hospice representatives to coordinate care to the resident(s) provided by the facility staff and the hospice staff. 5) Ensure that each resident's written plan of care includes both the most recent hospice plan of care as well as a description of the services provided by the LTC facility to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being...." This citation relates to Complaint IN00455065.			