STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 10, 11, 12, 13, and 14, 2023. Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 2 Medicaid: 32 Other: 7 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 21, 2023.	F 0000	The Waters of Huntington respectfully submits the following plan of correction as credible allegation of compliance to the mentioned regulatory tags listed below. We also ask that this plan of correction be considered for paper compliance/ desk review, as we have attached supportive documentation as proof of compliance.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Anna Foster | HFA | 08/03/2023

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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	sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving			

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	health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility staff failed to provide resident information to assure continuity of care for a resident's emergency transfer to an acute care hospital for 1 of 5 residents reviewed for hospitalization.	F 0622	It is the policy of this facility to provide resident information to an acute care hospital to assure continuity of care for a resident's emergency transfer. Unable to	08/03/2023

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	(Resident 6) Findings include: Resident 6's clinical record was reviewed on 7/13/23 at 3:04 p.m. Diagnoses included acute respiratory failure, heart failure, and intellectual disability. A nurses note, dated 5/23/2023 at 4:46 p.m., indicated the resident was transferred to the emergency room for evaluation of rapid breathing and oxygen saturation levels in the 70's. During an interview on 7/14/23 at 10:47 a.m., RN 2 indicated when a resident was sent to the emergency room, staff would send a copy of the resident's face sheet, advanced directive form, any recent laboratory or X-ray results, a completed e-Interact assessment form, and a change of condition assessment. She was unable to locate the assessments for Resident 6 for 5/23/23 in the electronic health record, nor evidence of the resident's personal information and advance directive having been sent. During an interview on 7/14/23 at 11:25 a.m., the DON indicated the staff were to send the e-Interact and change of condition assessments, a face sheet, advanced directive form, and a copy of the resident's orders with a resident when an emergency transfer was needed. If staff were unable to print them due to an emergency situation, the information should have been faxed to the hospital as soon as possible. Resident 6's electronic health record lacked completion of the needed assessments. Review of a current facility policy, dated 1/1/17, titled, "Transfer or Discharge Policy and		correct past alleged deficient practice for resident #6's hospitalization on 5/23/23. Resident #6 has returned from hospital and continues to reside in facility. Any resident who has an emergency transfer to an acute care hospital has the potential to be impacted by the alleged deficient practice. Director of Nursing/ Staff Development Coordinator in-serviced licensed nursing staff on 7/27/23 over Transfer and Discharge Policy and Procedure and proper documentation to be sent with a resident transferred for an emergency to an acute care hospital. Any employee who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Emergency transfers will be reviewed at the morning Interdisciplinary Team meeting to ensure proper documentation was provided to the acute care hospital. Any concerns will be addressed as discovered. Director of Nursing or Designee will monitor all emergency transfers using Quality Assurance tool titled Transfer and Discharge Communication Log (Attachment A) for eight weeks then monthly for four months, and as needed thereafter. Results of the monitoring will be reviewed at the	

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	Procedure," provided by the DON on 7/14/23 at 11:51 a.m., indicated the following: "...Procedure 1. The facility reserves the right to transfer a resident deemed acutely ill by the physician to a hospital...Emergency Transfer:...7. Complete the Resident Transfer for {SIC} make 2 copies of any portion of the health record necessary for care of the resident. (E.g. Physician's Orders, History & Physical, chest x-ray, immunization information, any pertinent lab work etc...." 3.1-12(a)(3)		monthly QAPI meetings with action plans developed by the QA committee as needed.	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed when hospice services were initiated for 1 of 4 residents reviewed for hospice services (Resident 42). Findings include: Resident 42's clinical record was reviewed on 7/11/23 at 3:16 p.m. Diagnoses included traumatic	F 0637	It is the policy of this facility to ensure a significant change MDS is completed for residents that initiate Hospice services. A significant change MDS was completed for resident #42 on 7/4/23 and 7/25/23. All residents receiving hospice services have the potential to be impacted by the alleged deficient	08/03/2023

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	subarachnoid hemorrhage with loss of consciousness status unknown and dementia. Current physician orders indicated hospice services had began on 5/4/23. An admission MDS assessment, dated 4/3/23, indicated she had not received hospice services. A quarterly MDS assessment, dated 7/4/23, indicated she had not received hospice services. The clinical record lacked a significant change MDS assessment after hospice services had been started. A current care plan, dated 5/15/23, indicated she would be followed by hospice care. During an interview on 7/13/23 at 2:49 p.m., the MDS Nurse indicated the significant change MDS assessment related to initiation of hospice services had been missed. She used the RAI (Resident Assessment Instrument) Manual as reference for completion of MDS assessments. Review of the current RAI manual, dated 7/7/23, indicated the following: "...Chapter 2: Resident Assessment Instrument (RAI)...required Assessment Summary," of the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual. The manual indicated, "...Significant Change in Status (SCSA) (Comprehensive)...14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)...03. Significant Change in Status Assessment...A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without		practice. All residents receiving hospice services in the last 30 days were audited to ensure a significant change MDS was completed as necessary. MDS Nurse was in-serviced on 7/13/23 and 7/31/23 on completion of significant change MDS assessment per RAI manual. Any staff who fail to comply with the points of the in-service will be further educated/or progressively disciplined as indicated. Hospice referrals and admissions will be discussed in morning Interdisciplinary Team meeting. MDS Nurse or Designee will audit any resident initiating Hospice services to ensure a significant change MDS is completed using MDS Audit Tool (Attachment B). This will occur weekly for eight weeks then monthly for four months, and as needed thereafter Results of the monitoring will be reviewed at the monthly QAPI meetings with action plans developed by the QA committee as needed.	

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	intervention by staff or by implementing standard disease-related clinical interventions...2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan ...An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) ...." 3.1-31(d)(1)			
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 record review and interview, the facility failed to assure collaborative communication with the hospice provider for 2 of 4 residents reviewed for hospice services. (Residents 14 and 15) Findings include: 1. Resident 14's clinical record was reviewed on 7/12/23 at 11:14 a.m. Diagnoses included multiple sclerosis, protein-calorie malnutrition, and depression. A health care plan, dated 5/23/23, indicated the resident received hospice services. Interventions included invite hospice to all care plan meetings and keep hospice staff updated on any care changes.	F 0684	It is the policy of this facility to assure collaborative communication with hospice providers for all residents receiving hospice services. Resident #14 was discharged from hospice services on 7/5/23. Hospice records for resident #15 in hospice binder at nurse's station. All residents receiving hospice services have the potential to be impacted by the alleged deficient practice. An audit was completed on 8/1/23 of all residents receiving hospice services to ensure documentation present in hospice binder at nurse's station.	08/03/2023

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	The resident was discharged from hospice services by the service provided on 7/5/23. The electronic health record and resident's paper chart lacked any documentation of the discharge. During an interview on 7/13/23 at 9:53 a.m., the DON indicated the facility had no documentation regarding the resident's hospice services. The resident was admitted to hospice, and had been recently discharged from hospice services, but the facility had been unable to locate any provider documentation for Resident 14. 2. Resident 15's clinical record review was completed on 7/11/23 at 2:38 p.m. Diagnoses included flaccid hemiplegia to his left side, history of cerebral infarction, and anxiety disorder. A current physician's order, dated 5/7/23, indicated the resident was to be admitted to hospice for diagnoses of stroke, hemiplegia, dysphagia, and vascular dementia. The resident's hospice documentation binder lacked documentation regarding services provided, and assessments completed, for the hospice skilled nursing visits. During an interview on 7/12/23 at 10:58 a.m., LPN 4 indicated she had not seen any documentation from the hospice staff. She signed the providers device to confirm they had completed a visit. The hospice binder lacked record of the resident's visits from the hospice staff. During an interview on 7/12/23 at 3:01 p.m., the Corporate Nurse Consultant indicated the facility should receive a record of each visit by the provider. At the time of the interview, the DON		Staff were in-serviced on 7/27/23 over policy and procedure for hospice services and collaborative communication with hospice provider. Any employee who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Director of Nursing or designee will audit hospice binder using Hospice Communication Log (Attachment C) to ensure collaboration of communication weekly for eight weeks then monthly for four months, and as needed thereafter. Results of the monitoring will be reviewed at the monthly QAPI meetings with action plans developed by the QA committee as needed.	

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	indicated the skilled nurse should be completing the "Hospice and Nursing Facility Communication Log" each visit. A current, undated facility policy titled, "Policy and Procedure Hospice Care," provided by the Corporate Nurse Consultant on 7/13/23 at 1:34 p.m., indicated the following: "...Procedure:...3. Hospice Care consultants and the facility will communicate in a manner that will ensure collaboration of care...."			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 3 residents reviewed for Transmission Based Precautions. (Resident 19) Findings include: During an initial tour observation on 7/10/23 at 10:01 a.m., Resident 19's room was observed to have no signage for EBP and no personal protective equipment (PPE) cart. On 7/11/23 at 10:20 a.m., a PPE cart was outside Resident 19's room. No signage was posted on the door. During an observation on 7/12/23 at 10:00 a.m. the PPE cart remained outside of the resident's door, but no signage. Resident 19's clinical record was reviewed on 7/13/23 at 9:30 a.m. A current physician order, dated 6/5/23 at 6:00 p.m., indicated Enhanced Barrier Precautions every shift for catheter and wounds. A 5/12/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident required extensive assistance for bed mobility. He was incontinent of bowel and had an indwelling catheter. An EBP sign was observed on Resident 19's door on 7/13/23 at 10:25 a.m. and the PPE cart remained in place. The sign included information in the	F 0880	It is the policy of this facility to implement and follow enhanced barrier precautions for those residents' meeting criteria. Resident #19 has proper signage and PPE cart outside resident's door following enhanced barrier precautions. Any resident requiring enhanced barrier precautions has the potential to be impacted by the alleged deficient practice. All residents on enhanced barrier precautions were audited and have proper signage on door and PPE carts outside. Infection Preventionist in-serviced nursing staff on 7/27/23 on Infection Prevention Policy and Procedure including caring for residents with enhanced barrier precautions. Any employee who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Any new residents requiring enhanced barrier precautions will have proper signage and PPE carts placed outside room and reviewed at Interdisciplinary Team meeting. Audits of PPE carts and signage will be completed by Infection Preventionist or Designee utilizing Enhanced Barrier Precautions Audit (Attachment D)	08/03/2023

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	bottom right hand corner to indicate it came from the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC). On 7/13/23 at 3:15 p.m., two unidentified staff members entered Resident 19's to reposition him in bed, per his request. They did not don PPE. Review of a document titled "Summary of Recent Changes" , retrieved on 7/14/23 at 1:36 p.m., from www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, indicated Enhanced Barrier Precautions were expanded to include residents with indwelling medical devices or wounds. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. During an interview on 7/14/23 at 2:16 p.m., LPN 3 indicated PPE should be worn during repositioning of a resident on EBP. It could be acceptable to enter the resident's rooms without PPE for activities which did not include direct contact with the resident. 3.1-18(b)(2)		weekly for eight weeks then monthly for four months, and as needed thereafter. Five staff observations of care for residents on enhanced barrier precautions will be completed weekly for eight weeks then monthly for four months, and as needed thereafter. Results of the monitoring will be reviewed at the monthly QAPI meetings with action plans developed by the QA committee as needed. All systematic changes for the alleged deficiencies/ POC were completed by 8/3/23.	