STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155571	A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DUNKIRK SKILLED NURSING FACILITY, THE	11563 W 300 S DUNKIRK, IN 47336

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00409625. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00409625 - Federal/State deficiencies related to the allegations are cited at F726 and F835. Survey dates: June 14 and 15, 2023 Facility number: 000519 Provider number: 155571 AIM number: 100287230 Census Bed Type: SNF/NF: 38 SNF: 3 Total: 41 Census Payor Type: Medicare: 3 Medicaid: 29 Other: 9 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 19, 2023.	F 0000		
F 0726 SS=F Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or			

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

Tyisha Wheeler | Administrator | 07/07/2023

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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	maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on interview and record review, the facility failed to ensure residents received medications, including insulin injections, from qualified nursing personnel and failed to ensure medications were prepared and administered within professionally accepted standards for 5 of 5 residents reviewed for medication administration (Residents B, C, E, F, and G). These deficient practices had the potential to effect 41 of 41 residents in the facility. Findings include:	F 0726	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk	06/16/2023

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	Review of a facility self reportable, dated 5/26/2023 indicated on 5/25/2023, during job shadowing activity, LPN 1 allowed a nursing student to pass medications to five facility residents. During an interview, on 6/14/2023 at 10:37 a.m., the Administrator indicated they had not been aware of LPN 1's daughter (who was the nursing student named in the report) job shadowing her until they were contacted by concerned staff, who reported witnessing the nurse's daughter administering medications to residents. The Administrator indicated LPN 1 had requested permission to do the job shadowing from the DON. The Director of Nursing was out of the facility during the time of the survey. The facility did not have a contract with a nursing program for clinical rotation. During an interview, on 6/14/2023 at 10:42 a.m., CNA 3 indicated during the evening shift on 5/26/2023, they witnessed LPN 1 and her daughter administering medication to several residents. CNA 3 had witnessed LPN 1's daughter administer insulin to Resident G. CNA 3 and other staff became concerned and called the Administrator. CNA 3 did not know the nursing student personally, but knew she was the daughter of LPN 1. During an interview, on 6/14/2023 at 12:25 p.m., QMA 4 indicated they had been working when LPN 1's daughter was job shadowing her. QMA 4 was insulin qualified, but the facility did not allow QMAs to give insulin. She usually draw up the insulin for LPN 1, to be nice to her. She knew she was not supposed to prepare medication for someone else. The nurse told her not to draw up the insulin that day, because she was going to do it with the student. QMA 4 believed the nursing		review for all deficiencies in the Plan of Correction. We would like to request past compliance acceptance related to the deficiencies. ¿ F726: It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident ol="" role="list" start="1" Corrective actions for identified residents affected by the cited practice. Residents B, C, E, F, and G were assessed at the time of the occurrence with no negative findings. LPN #1 and QMA #4 are no longer employed by the facility. Identification of other residents who may be affected by the cited practice and corrective action(s) that will be put in place to ensure the practice does not recur. Residents with medication orders have the potential to be affected by the cited practice. All residents residing in the facility at the time of the occurrence were interviewed to identify any other residents who may have been administered medications by a non-licensed person. Any identified residents were assessed with vital signs obtained at the	

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	student was there as part of a clinical rotation. During an interview, on 6/14/2023 at 1:35 p.m., LPN 6 indicated QMAs were not allowed to administer insulin in the facility. They would not allow a QMA to draw up insulin or pre-set any medications. During an interview, on 6/14/2023 at 1:48 p.m., QMA 7 indicated the facility did not allow QMAs to give insulin. QMAs checked the blood sugars, and the nurses administered the insulin. She never drew up the insulin for the nurse. It was not in her scope of practice. During an interview, on 6/14/2023 at 1:56 p.m., Resident E indicated a few weeks ago someone gave her an insulin shot who should not have. They did not work in the facility. At the time, she was told they were here for training. She thought it was a new employee. The next day she found out that was not true. She felt like she was lied to. If she had known the truth, she would not have allowed them to give her the insulin. During a phone interview, on 6/15/2023 at 9:45 a.m., the DON indicated LPN 1 requested to have her daughter job shadow her. She gave LPN 1 permission because the facility had allowed it in the past. In the past, potential new hires would ask to job shadow nurses and aides. The facility did not have a policy for job shadowing. The DON defined job shadowing as "observation only". At no time did she give LPN 1 permission for the daughter to provide resident care or administer medications. The DON did not inform the Administrator she gave LPN 1 permission to have the daughter job shadow. The DON did not define the definition of "job shadowing" with LPN 1 when permission was granted.		time. p="" paraid="915045934" paraeid="{9e0429a0-36b5-49ab-90d3-1666d588a7ab}{31}">Licensed nurses and QMAs were interviewed to identify if any other scope of practice concerns were present with none identified. Measures put in place and systemic changes you will make to ensure the cited practice does not recur. Licensed nurses and QMAs were re-educated on 5-26-23 by the ADON relative to Competent Nursing Staff, including but not limited to, medication administration and performing within their respective Scopes of Practice; and the Indiana State Nurse Practice Act, including but not limited to, responsibilities of the RN/LPN to apply the nursing process, responsibilities as a member of the health care team, and relative to what constitutes unprofessional conduct. Any staff member that fails to comply with the points of this in-service will be further educated and/or progressively disciplined as indicated. DON/Designee, daily on scheduled days of work, will audit to verify no individuals are job shadowing for 6 months. Any identified concerns will be addressed immediately and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted an action	

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	During an interview on, 6/15/2023 at 11:05 a.m., the Administrator and ADON indicated the facility did not have a policy or any type of guidance for job shadowing. The Administrator and ADON defined job shadowing as observation only - not to perform any duties. Only nurses and QMAs were allowed to administer medication. LPN 1 was no longer employed at the facility, and was unable to be reached for interview. Review of a written statement from LPN 1's daughter/Nursing Student 2 indicated she had administered insulin to five residents. The student believed this to be part of the job shadowing. A list of the resident names was provided by the Administrator on 6/15/23. Review of a written statement from LPN 1, dated 5/26/2023, indicated she had been given permission to have her daughter job shadow her. Her daughter was a RN candidate and she believed she was allowed to administer insulin. The student was also diabetic, and administered insulin to herself. a. The clinical record for Resident B was reviewed on 6/14/2023 at 12:00 p.m. Diagnoses included type 2 diabetes and vascular dementia. b. The clinical record for Resident C was reviewed on 6/14/2023 at 12:11 p.m. Diagnoses included cerebrovascular disease and type 2 diabetes. c. The clinical record for Resident E was reviewed on 6/14/2023 at 12:39 p.m. Diagnoses included chronic heart failure and type 2 diabetes.		plan may be established. Date of Compliance: 5-26-23	

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	d. The clinical Record for Resident F was reviewed on 6/14/2023 at 12:43 p.m. Diagnoses included type 2 diabetes and stage 3 chronic kidney disease. e. The clinical record for Resident G was reviewed on 6/14/2023 at 12:46 p.m. Diagnoses included type 2 diabetes and Parkinson's disease. Review of a current, undated, facility policy titled "Medication Administration," indicated the following: ".... 1. Licensed professional nurses administer medications according to times documented on the Medication Administration Record...." Review of an online document, titled "Medication Administration: NCLEX-RN," dated 2/15/23 and retrieved from https://www.registerednursing.org/nclex/medication-administration, indicated the following: "...Nurses are legally and ethically responsible and accountable for accurate and complete medication administration, observation, and documentation...." This Federal tag relates to complaint IN00409625. 3.1-14(j) 3.1-25(b)(1) 3.1-47(a)(1)			
F 0835 SS=F Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.			

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	Based on interview and record review, the facility management team allowed an unqualified individual, who was not employed or contracted with the facility, to provide care and have access to resident information. The facility failed to ensure residents did not receive medications, including insulin injections, from an unqualified individual for 5 of 5 residents reviewed for medication administration. This deficient practice had the potential to affect 41 of 41 facility residents. Findings include: Review of a facility self reportable, dated 5/26/2023 indicated on 5/25/2023, during job shadowing activity, LPN 1 allowed an unlicensed nursing student to pass medications to five facility residents. During an interview, on 6/14/2023 at 10:37 a.m., the Administrator indicated they had not been aware of LPN 1's daughter (who was the nursing student named in the report) job shadowing her until they were contacted by concerned staff, who reported witnessing the nurse's daughter administering medications to residents. The Administrator indicated LPN 1 had requested permission to do the job shadowing from the DON. The Director of Nursing was out of the facility during the time of the survey. The facility did not have a contract with a nursing program for clinical rotation. During a phone interview, on 6/15/2023 at 9:45 a.m., the DON indicated LPN 1 requested to have her daughter job shadow her. She gave LPN 1 permission because the facility had allowed it in the past. In the past, potential new hires would ask to job shadow nurses and aides. The facility did not have a policy for job shadowing. The	F 0835	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for all deficiencies in the Plan of Correction. We would like to request past compliance acceptance related to the deficiencies. F835: A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1. Corrective actions for identified residents affected by the cited practice. Resident B, C, E, F, and G were assessed with no negative findings on 5-26-23 2. Identification of other residents who may be affected by the cited practice and corrective action(s) that will be put in place to ensure the practice does not recur. Residents with medication orders have the potential to be affected by the cited practice. All residents residing in the facility at the time of the occurrence were interviewed	06/16/2023

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	DON defined job shadowing as "observation only". At no time did she give LPN 1 permission for the daughter to provide resident care or administer medications. The DON did not inform the Administrator she gave LPN 1 permission to have the daughter job shadow. The DON did not define the definition of "job shadowing" with LPN 1 when permission was granted. During an interview, on 6/15/2023 at 11:05 a.m., the Administrator and ADON indicated the facility did not have a policy or guidance for job shadowing. The Administrator and ADON defined job shadowing as observation only - not to perform any duties. Neither were aware of the job shadowing event until contacted by staff with concerns. Cross reference F726. This Federal tag relates to complaint IN00409625. 3.1-13(a)(1)		to identify any other residents who may have been administered medications by a non-licensed person. Any identified residents were assessed with vital signs obtained at the time. 3. Measures put in place and systemic changes you will make to ensure the cited practice does not recur. On 5-26-23 Regional Director of Operations educated Administrator on the expectation of no job shadowing in the building. On 5-26-23 the Administrator educated the Department Leaders on Qualified Personnel to include not allowing non-qualified personnel to job shadow staff members. Licensed nurses and QMAs were re-educated on 5-26-23 by the ADON relative to Competent Nursing Staff, including but not limited to, medication administration and performing within their respective Scopes of Practice; and the Indiana State Nurse Practice Act, including but not limited to, responsibilities of the RN/LPN to apply the nursing process, responsibilities as a member of the health care team, and relative to what constitutes unprofessional conduct. Any staff member that fails to comply with the points of this in-service will be further educated and/or progressively disciplined as indicated. DON/Designee, daily on scheduled days of work, will audit	

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			to verify no individuals are job shadowing for 6 months. Any identified concerns will be addressed immediately and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted an action plan may be established. Date of Compliance: 5-26-23	