STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155304	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN 47362

(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: September 26, 27. 28, and 29, 2023. Facility number: 000201 Provider number: 155304 AIM number: 100267910 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 10 Medicaid: 39 Other: 4 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 4, 2023	F 0000	Preparation or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusion set forth on the Statement of Deficiencies. The Plan of Correction is prepared as the position and executed solely because it is required by the position of Federal and State Law. The Plan of correction is submitted in order to respond to the allegation of noncompliance cited during an Annual Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance on October 16, 2023.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to provide fresh ice water for 1 of 2 residents reviewed for hydration	F 0558	F558 It is the policy of this facility to ensure all residents have the right	10/16/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittney L. Longnecker	Health Facility Administrator	10/17/2023

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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	(Resident 4). Finding include: During an observation and interview on 9/27/23 at 1:52 p.m., Resident 4 indicated she had to ask if she wanted ice water, she hasn't gotten fresh ice water since last night. The facility staff were observed passing out fresh ice water and went by Resident 4's room without providing fresh water. During an observation on 9/27/23 at 2:40 p.m., Resident 4 continues to have a half cup of warm water. The resident indicated her and her roommate had not received fresh water since last night. During an observation on 9/28/23 at 9:45 a.m., Resident 4 continues with the same half cup of warm water with no fresh ice water available. During an observation on 9/28/23 at 11:00 a.m., Resident 4 continues with a cup of warm water with no fresh ice water available. Resident 4 was laying in bed with her eyes closed. During an interview and observation on 9/28/23 at 1:42 p.m., Resident 4 had two cups of warm water. The resident indicated she frequently did not receive fresh ice water, she often had to request ice water from staff. Review of the record of Resident 4 on 9/28/23 at 10:28 a.m., indicated the resident's diagnoses included, but were not limited to, age related physical debility, osteoarthritis, pain in right/left knee atrial fibrillation, hypertension, urinary tract infection, gout, anxiety and major depressive		to receive services within the facility per their accommodation and preference for fresh ice water on each shift. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #4 was immediately provided with fresh ice water and drinking cup was marked with date ice water was provided. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. 3. What measures will be put in place or systemic measures to ensure the deficient practice will not recur? All nursing staff in-serviced by Director of Nursing on policy to ensure fresh ice water is distributed daily on each shift on 10/2/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. Audit sheet created for staff to initial, date, and mark time of ice water that is passed for each shift. 4. How will the facility monitor its corrective actions to ensure that	

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	disorder. The plan of care for Resident 4, dated 10/18/22, indicated the resident was at risk for dehydration related to diuretic medication use. The interventions were monitor weight and vital signs, observe for increased signs of edema and report any changes to the physician. The Quarterly Minimum Data (MDS) assessment for Resident 4, dated 7/20/23, indicated the resident was cognitively intact for daily decision. The resident was consistent and reasonable. During an interview with the Director Of Nursing (DON) on 9/28/23 at 2:20 p.m., indicated the facility protocol for providing residents with fresh ice water was it was passed first thing in the morning and in the evening. The facility also had a drink cart that passed out fluids twice a day. The DON indicated it was nursing's responsibility to ensure Resident 4 had fresh ice water. 3.1-3(v)(1)		the deficient practice will not recur? Director of Nursing/Designee will use Ice Water audit tool to monitor for compliance 5 times a week x 4 weeks, then 3 times a week x 4 week, the weekly for 4 months. . If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5. Date of correction: 10/16/23	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.			

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	§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure a resident's privacy curtain was wide enough to provide full visual privacy. This affected 1 of 1 resident reviewed. (Resident 32) Findings include: On 9/27/23, at 11:11 a.m., Resident 32's curtain, between her bed and her roommate's bed, was observed and did not extend from the wall at the head of her bed to the wall past the foot of her bed. The area from the foot of her bed to the wall past the foot of her bed was left exposed for approximately 4 feet. The track on the ceiling, that	F 0583	F583 It is the policy of this facility for each resident to have the right to personal privacy with a privacy curtain. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident#32 was immediately provided with extended curtain to provide privacy for resident from head of bed to foot of bed on 9/29/23. 2.How will the facility identify	10/16/2023

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	the curtain was hung from, extended from the wall at the head of her bed to the wall that went past the foot of her bed. There were 10 empty curtain hooks in the curtain track. Resident 32 indicated that anyone could see her in her bed if they walked into her room because the curtain didn't go down far enough. On 9/28/23, at 2:45 p.m., Resident 32 was in bed, with her eyes closed, and the curtain between the beds was not wide enough to extend from wall to wall for privacy. Resident 32's record was reviewed, on 9/28/23, at 11:16 a.m. and indicated diagnoses, that included, but were not limited to, right knee contracture, type 2 diabetes mellitus, generalized muscle weakness, and difficulty in walking. A quarterly Minimum Data Set assessment, dated 8/16/23, indicated Resident 32 was cognitively intact. On 9/29/23, at 11:47 a.m., Resident 32 was in her room, seated in a wheelchair, and the curtain was observed with the Administrator. The Administrator indicated the curtain should be wide enough to go to the wall. A Policy for "Dignity" was provided by the Administrator, on 9/29/23, at 1:10 p.m., and included, but was not limited to..."Privacy...4.) Staff will provide privacy for residents during any personal care and/or treatment. The privacy curtain must be pulled anytime that the resident needs to have privacy. Examples include but are not limited to bathing, showers, and so on...." 3.1-3(p)		other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. Housekeeping supervisor completed full resident audit on 9/29/23 for all residents to ensure each resident had a full length privacy curtain in place for dignity. 3. What measures will be put in place or systemic measures to ensure the deficient practice will not recur? Administrator in serviced housekeeping supervisor and housekeeping staff that all resident curtains must meet length of resident bed to provide privacy to residents. Inservice completed 9/29/23. Additionally, any staff member that fails to comply with the points of this in-service will be further educated/disciplined as indicated. Full facility audit of all residents was conducted to ensure all residents were provided with a full length privacy curtain. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Housekeeping Supervisor will use Privacy Curtain Audit tool to monitor for compliance weekly for 4 weeks and then monthly for 6 months. . If the facility is within 95% compliance at the end of the	

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			6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5. Date of correction: 10/16/23	
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 reviewed, the facility failed to accurate code six-month prognosis and hospice services (Resident 12) and medications (Resident 16) for 2 of residents reviewed for Minimum Data Set (MDS) accuracy. Findings include: 1. The clinical record for Resident 12 was reviewed on 9/29/2023 at 11:05 a.m. The medical diagnosis included respiratory failure with hypoxia. A Quarterly MDS assessment, dated got 6/28/2023, indicated that Resident 12 did not have a six-month or less prognosis and did not receive hospice services. A Quarterly MDS assessment, dated for 9/28/2023, indicated that Resident 12 did not have a six-month or less prognosis.	F 0641	F641 **It is the policy of this facility to accurately code a six-month prognosis and hospice services and** medications on an MDS assessment for any resident that meets these requirements. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Facility completed a modified MDS assessment for both Resident 12 and Resident 16 to include 6 month prognosis and hospice services on 9/29/23. 2.How will the facility identify other residents having the potential to be affected by the	10/16/2023

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	A physician order, dated 5/6/2021, indicated Resident 12 received hospice services. A hospice recertification, dated 3/19/2023, indicated Resident 12 has a six month or less prognosis if disease runs its normal course and was recertified for hospice services. 2. The clinical record for Resident 16 was reviewed on 9/29/2023 at 10:55 a.m. The medical diagnosis included chronic obstructive pulmonary disease. A Quarterly MDS assessment, dated 7/17/2023, indicated that Resident 16 received seven days of anticoagulation medication. The medication administration record for Resident 16 for July 2023, indicated that Resident 16 did not receive anticoagulation medication. An interview with the MDS Coordination on 9/29/2023 at 11:02 a.m. indicated that she could not find where Resident 16 used anticoagulation medications and verified that Resident 12 was on hospice services during the aforementioned quarterly assessments. She indicated she would be modifying the assessments discussed and that they code to the MDS Resident Assessment Instrument.		same deficient practice? All residents have the potential to be affected by this deficient practice that meet these requirements and are on hospice services and on an anticoagulant. Facility completed full resident audit 10/2/23 for all residents receiving hospice services, a six month prognosis, and anticoagulant to ensure all MDS assessments are coded accurately. 3. What measures will be put in place or systemic measures to ensure the deficient practice will not recur? MDS Coordinator in-serviced by Administrator on policy that each resident that has a six month prognosis and on hospice services and receives an anticoagulant will be coded accurately on their MDS Assessment. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. This was coded that someone was receiving an anticoagulant and they were not. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? MDS Coordinator will use MDS audit tool for compliance weekly for 4 weeks and then monthly for 6 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped.	

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			Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5. Date of correction: 10/16/23	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will			

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	provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review the facility failed to develop a plan of care for a resident with recurrent Urinary Tract Infections (UTI) for 1 of 1 resident reviewed for UTI (Resident 4). Finding include: Review of the record of Resident 4 on 9/28/23 at 10:28 a.m., indicated the resident's diagnosis included, but were not limited to, chronic Urinary Tract Infection (UTI). The physician order for Resident 4, dated 7/21/23, indicated the resident was ordered to be seen by the urologist for recurrent UTI's. The physician order for Resident 4, dated 8/16/23,	F 0656	F656 It is the policy of this facility to ensure a care plan is implemented specific to each resident and their diagnosis. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident # 4 care plan was immediately reviewed, and a UTI care plan has been added specific to resident diagnosis and treatment by MDS Coordinator on 9/29/23 2.How will the facility identify	10/16/2023

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	indicated the resident was ordered keflex (antibiotic) 250 milligrams (mg) indefinitely for recurrent UTI's. The urology report for Resident 4, dated 9/18/23, indicated the resident was being seen for recurrent UTI's. During an interview with Resident 4 on 9/28/23 at 1:42 p.m., indicated she had a long history of UTI's. During an interview with the Director Of Nursing (DON) on 9/28/23 at 2:20 p.m., verified Resident 4 did not have a plan of care in place for UTI's. The DON indicated it was the responsibility of the Minimum Data Set (MDS) Coordinator in develop the plan of care. The care plan policy provided by the Administrator on 9/29/23 at 10:50 a.m., indicated the facility Interdisciplinary team in conjunction with the resident, resident's family as appropriate along with a "hands on" caregiver, such as a certified nursing assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well being attainable for the resident. 3.1-35(a)		other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. Resident audit completed for any resident that has diagnosis of UTI that a care plan is in place by MDS Coordinator on 10/2/23. 3. What measures will be put in place or systemic measures to ensure the deficient practice will not recur? Administrator/designee in-serviced the Nurse Mangers on implementing care plans for residents with recurring urinary tract infections on (date). Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? IDT Nurse management team will use care plan audit tool to monitor for compliance weekly for 4 weeks and then monthly for 6 months. . If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any	

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			written Action Plan will be monitored by the Administrator weekly until resolved. 5. Date of correction: 10/16/23	
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 observation, interview and record review the facility failed to assess and monitor bilateral feet edema (swelling) for 1 of 1 resident reviewed for edema (Resident 4). Finding include: During an observation on 9/27/23 at 2:01 p.m., Resident 4 was sitting in a chair, her bilateral feet were swollen. During an observation and interview with Resident 4 on 9/28/23 at 1:42 p.m., the resident was laying in bed, her bilateral feet were swollen. The resident indicated her feet did swell often. The resident indicated nursing had not assessed her feet edema. Review of the record of Resident 4 on 9/28/23 at 10:28 a.m., indicated the resident's diagnoses included, but were not limited to, age related physical debility, osteoarthritis, pain in right/left	F 0684	F684 – It is the policy of this facility to ensure all resident's receive treatment and care as ordered by physician to assess and monitor for swelling (Edema) 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident # 4 with current diagnosis of edema was immediately reviewed and orders have been immediately updated to include nurse to assess and monitor for swelling. Resident was immediately assessed by DON, MDS Coordinator and Nurse Practitioner on 9/28/23. MD notified.. 2.How will the facility identify	10/16/2023

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	knee atrial fibrillation, hypertension, urinary tract infection, gout, anxiety and major depressive disorder. The plan of care for Resident 4, dated 10/18/22, indicated the resident was at risk for dehydration related to diuretic medication use. The intervention included, but were not limited to, observe for increased signs of edema and report any changes to the physician. The plan of care for Resident 4, dated 10/18/22, indicated the resident had a diagnosis of atrial fibrillation. The intervention included, but were not limited to, observe for signs and symptoms of edema. The Quarterly Minimum Data (MDS) assessment for Resident 4, dated 7/20/23, indicated the resident was cognitively intact for daily decision. The resident was consistent and reasonable. During an interview with the Director Of Nursing (DON) on 9/28/23 at 2:20 p.m., indicated the expectation of the facility was nursing would be assessing and monitoring Resident 4's bilateral feet edema. The DON indicated she could not find an assessment/monitoring of the resident's edema and would continue looking for it. During an interview the DON on 9/29/23 at 11:15 a.m., indicated she was not able to find an assessment from nursing for Resident 4's bilateral feet swelling. The DON indicated there was a physician order now to monitor the edema every shift now. 3.1-37(a)		other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. A facility audit has been conducted by DON on 10/2/23 to review all residents with diagnosis of edema to include an order to monitor and assess for swelling. 3. What measures will be put in place or systemic measures to ensure the deficient practice will not recur? Nursing Staff was in-serviced by Director of Nursing/Designee on (date) regarding order required for any resident with diagnosis of edema to include order for nurse to monitor and assess for swelling. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Director of Nursing/Designee will use diagnosis tracking tool to monitor for compliance weekly for 4 weeks and then monthly for 6 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN 47362

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			needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5. Date of correction: 10/16/23	