STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155202	A. BUILDING 00 B. WING	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00396171 and IN00399519. Complaint IN00396171 - No deficiencies related to the allegations are cited. Complaint IN00399519 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: March 14 and 15, 2023 Facility number: 000109 Provider number: 155202 AIM number: 100266290 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 7 Medicaid: 50 Other: 9 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 23, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is April 3, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after April 3, 2023.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Etienne	Administrator	04/01/2023

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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	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 ensure a skin assessment and post fall assessment were completed for 1 of 3 residents reviewed for accidents (Resident C). Findings include: Resident C's record was reviewed on 3/14/2023 at 1:57 p.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), type 1 diabetes (a chronic condition in which the pancreas produces little or no insulin), hyperlipidemia (known as high cholesterol, when there are too many lipids (fats) in the blood), depression (a mental health disorder with persistently depressed mood or loss of interest in activities, causing impairment in daily life), chronic pancreatitis (a condition where the pancreas (a small organ located behind the stomach) becomes permanently damaged from inflammation). A quarterly Minimum Data Set (MDS) assessment, dated 11/22/2022, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was cognitively intact. The resident was continent of bladder and occasionally incontinent of bowel. The resident required extensive assist of 2 persons with bed mobility and one-person physical assist with toilet use, dressing, and personal hygiene.	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of this facility to provide quality of care with the fundamental principles that is applied to all treatments and care that is provided to the facility residents. Resident C no longer resides at the facility. 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 have the potential to be impacted by this deficient practice. The DON and/or designee performed review of clinical records for post-fall assessment and post-fall skin assessment of current residents within last 30 days to ensure post-fall assessments and post-fall skin assessments were completed. No negative outcomes were noted with the 30 day look back as of March 16, 2023. What measures will be put into place or what systemic changes will be made	04/03/2023

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	A care plan, dated 11/18/2022, and revised on 12/21/2022, indicated the resident was a risk for falls due to decline in mobility, shortness of breath and malnutrition. Interventions included, but were not limited to, attempt to keep areas free of clutter, initiate "floor bed" to decrease risk of injury, keep call light in reach, and offer to assist resident to walk with staff as resident requests, pending the ability to do so safely. A care plan, dated 11/18/2022, indicated the resident was a risk for skin breakdown due to diagnosis of COPD, chronic pancreatitis, EtOH (alcohol), and meth (methamphetamine is a synthetic stimulant that is addictive and can cause considerable health adversities) abuse. Interventions included, but were not limited to, skin assessment per facility policy and keep clean and dry. The care plan lacked documentation of any skin injuries. Review of fall risk review, dated 12/16/2022 at 6:27 a.m., indicated resident was a high risk for falls with a score of 17. Review of nursing progress note, dated 12/16/2022 at 8:19 a.m., indicated resident had a fall. The doctor and son were notified. Review of daily skilled nursing note, dated 12/17/2022 at 1:42 a.m., indicated the resident had a fall. The doctor was notified and gave an order for a one time dose of Xanax (medication used to treat anxiety) 0.5 milligrams (mg). Review of IDT (interdisciplinary team) note, dated 12/17/2022, indicated resident was found on the floor in her room, resident indicated she was attempting to try to go to the bathroom. No injuries noted at this time.		to ensure that the deficient practice does not recur: The DON/Designee educated the nursing staff related to timely completion and documentation of post-fall assessment, post-fall skin assessment, and post-fall injury follow-up, the policy “Incidents/Accidents/Falls" on 3/15/2023. 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: The DON or designee will utilize a monitoring tool for review of clinical records related to completion of post-fall assessment, post-fall skin assessment, and post-fall injury follow-up. This will be accomplished five (5) days per week by completing monitoring reviews for compliance for four (4) weeks, then two (2) times per week for four (4) weeks, then monthly x 4 months. If the facility is within compliance at the end of 6 months; then monitoring can be stopped. Any deficient practices will be corrected immediately. Audit findings will be reported to the QAPI Committee monthly. The committee will determine if further monitoring is warranted. **By what date will the**	

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	Review of nursing progress noted, dated 12/20/2022 at 7:47 a.m., indicated resident was found on the floor in her room. No injuries were noted. Hospice and family were notified. The record lacked documentation of a post fall assessment. Review of IDT note, dated 12/21/2022, indicated resident was found in the seated position on her floor mat, she was in between her bed and wheelchair. Resident noted to have a small skin tear on her left arm. The skin tear was closed with steri-strips. The record lacked documentation of a progress note of the fall, post fall assessment, and skin assessment. Review of December 2022 TAR (treatment administration record) indicated the record lacked documentation of treatment for the resident's skin tear on her left forearm. During an interview, on 3/15/2023 at 2:00 p.m., the Director of Nursing (DON) indicated a skin assessment should be completed weekly and after an event. Any new skin areas should be documented on the skin assessment. During an interview, on 3/15/2023 at 2:45 p.m., the Administrator (ADM) indicated they were not able to provide documentation of a post fall assessment for the falls that occurred on 12/20/2022 and 12/21/2022. She further indicated there were no skin assessments related to the skin tear. On 03/14/2023 at 11:25 a.m., the ADM provided an undated document, titled, "Incidents/Accidents/Falls," and indicated it was the policy currently being used by the facility.		**systematic changes be completed: April 3, 2023**	

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	The policy indicated, " ...Procedure: ... 2. In the case of a fall, the resident will have a head to toe assessment ...7 ....a progress note within the resident's medical record is to be included ...." This Federal tag relates to Complaint IN00399519. 3.1-37(a)			