STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155576	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HARTFORD CITY SKILLED NURSING FACILITY	0548 S 100 W HARTFORD CITY, IN 47348

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 5, 6, 7, 8, and 9, 2024. Facility number: 000289 Provider number: 155576 AIM number: 100289460 Census Bed Type: SNF: 1 SNF/NF: 31 Total: 32 Census Payor Type: Medicare: 1 Medicaid: 28 Other: 3 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2024.	F 0000	March 1, 2024 To Indiana State Department of Health, Enclosed you will find our credible alleged compliance of our plan of correction for the survey event ID: RBIP11. We have submitted our plan of correction through the Gateway System including the plan of correction, policies, and tools as described in our plan of correction. We have set up our compliance date for March 1, 2024. We respectfully request an opportunity for paper compliance for the F 686 SS=D Treatment/Services to Prevent/Heal Pressure Ulcer and F 645 SS=D PASARR Screening MD & ID citations. Please contact us if you would like us to submit additional supporting documentation paper compliance. Respectfully Submitted, Max Richardson Administrator The Waters of Hartford City 548 South 100 West Hartford City, IN 47348	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Max Richardson	Administator	02/29/2024

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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	residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the			

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	admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on interview and record review, the facility failed to ensure a preadmission screening and resident review (PASRR) was completed when the initial authorization for placement expired for 1 of 4 residents reviewed for PASRR. (Resident 12) Finding includes: Resident 12's clinical record was reviewed on 2/8/24 at 11:12 a.m. Her current diagnoses included bipolar disorder, other schizoaffective disorders, and major depressive disorder, recurrent. Current physician orders included bupropion hydrochloride extended release (antidepressant)	F 0645	The Waters of Hartford City respectfully submits the following plan of correction as a credible allegation of compliance to the above-mentioned regulations F-645. Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of 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	03/01/2024

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	300 mg daily, hydroxyzine 50 mg (used for anxiety) three times a day and quetiapine fumarate (antipsychotic) 100 mg daily and 150 mg at bedtime. An 11/25/23 quarterly minimum data set (MDS) assessment indicated the resident received antipsychotic, antianxiety, antidepressant, and hypnotic medications. A general progress note, dated 1/2/24 at 1:45 p.m., indicated the resident had 14 angry outbursts since admission and was being followed by a mental health services provider. A PASRR Level l screen outcome, dated 11/13/23, indicated the resident had an exempted hospital discharge. A 30-day approval or less stay in the nursing facility was authorized. Re-screening was to have occurred on or before the 30th day if the individual expected to remain in the nursing facility beyond the authorization timeframe. The end of authorization date was 12/13/23. During an interview, on 2/9/24 at 9:03 a.m., the Admissions Nurse indicated she had missed the 12/13/23 date to resubmit the PASRR as she had not realized the PASRR had been for 30 days when the resident admitted. A new PASRR was submitted on 1/10/24. A PASRR Level l screen, provided by the Social Services Designee (SSD) on 2/9/24 at 9:05 a.m., indicated the Level l had been submitted on 1/10/24 and indicated a Level 2 onsite evaluation must be conducted. A PASRR Level 2 screen, provided by the SSD on 2/9/24 at 9:05 a.m., indicated the Level 2 had a determination date of 1/17/24 and an effective date		Laws. Facility's date of alleged compliance is 3/1/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** F 645 SS=D PASARR Screening for MD & ID 1 It is the policy of The Waters of Hartford City to ensure preadmission screening and resident reviews (PASARRs) are completed prior to the initial authorization for placement has expired. 2 The level 2 and appropriate PASARR assessments for Resident #12 have been completed by the MDS Coordinator on 1/10/2024. 3 All residents have the potential to be affected. The MDS Coordinator has reviewed all resident's PASARRs, and no other residents were found to be out of compliance. The MDS Coordinator has also reviewed all resident diagnoses for mental disabilities and intellectual disabilities finding all appropriately matched the respective PASSARs, care plans and assessment documentation. 4 The social services consultant educated relevant management team members on the PASARR process and expiration. Any members that fail to comply with the points of the in-service will be further educated and/or progressively disciplined as	

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	of 1/10/24. According to a web document from Maximus, the Indiana PASRR screening provider, dated 2022, titled "Indiana PASRR FAQs for Providers," accessed on 2/12/24 at 10:18 a.m. at https://maximusclinicalservices.com/sites/default/files/pasrr/documents/IN%20PASRR%20FAQ_S%202021%20-%207.15.22.pdf, " ...If the person requires a stay longer than the 30-day EHD [Exempted Hospital Discharge] approval period, a new Level I and a LOC [Level of Care] are required to complete the full Level II. Please submit a Level I and a LOC 7 days prior to the end of the 30-day approval to avoid Federal compliance issues ...." A facility document, dated 5/17/23, titled "Guidelines for PASRR Process," provided by the Administrator on 2/9/24 at 3:26 p.m., indicated " ...An initial PASRR Level l Screening (PL1) of every person, (resident), apply for NF [nursing facility] placement to identify people, (residents), suspected of having ID [intellectual disability], DD [developmental disability], or MI [mental illness]. If the initial screening is positive, (meaning the person may have ID, DD, or MI), a PASRR evaluation, (PE), is completed by a qualified and impartial reviewer. People, (residents), who are confirmed to have ID, DD, or MI are evaluated to determine the need for specialized services, and appropriate placement options are reviewed ...." 3.1-16(d)(1)(B)		necessary. In-service was completed 2/26/2024 see attendance log (Attachment A). 5 To ensure that this deficient practice does not re-occur the Quality Improvement Audit Tool “PASARR Review” (Attachment B) was be completed by the Social Services Director or designee for all residents facility wide on 2/27/2024. The Social Services Director or designee will audit 10 residents for PASARR compliance weekly x 4 weeks, then 5 residents weekly x 4 weeks, then 5 residents monthly x 4 months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the audit be reviewed. Any concerns will have been corrected as found, then logged on the Quality Improvement Summary Log (Attachment C). Any patterns will be identified. If necessary, an Action Plan will be written by the committee, any action plan will be monitored by the Administrator weekly until resolution is met. 6 All Systemic changes will be in place by 3/1/2024.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to implement and review individualized interventions to prevent the development of a pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident 32) Finding includes: During an observation on 2/5/24 at 10:57 a.m., Resident 32 was sitting in her room in her wheelchair with a heel boot on her left leg and foot. During a wound observation on 2/7/24 at 9:11 a.m., the bandage was removed from the pressure injury to the left heel. The wound was the size of a half dollar in length, the size of a quarter in width, and had a 0.1 cm depth. The center of the wound was tan slough (nonviable tissue) with the length of the entire wound and the width of a pencil eraser. During an interview, at the time of the observation, the ADON indicated the area had started as a blood blister and developed an eschar cap (necrotic tissue). The Wound Nurse Practitioner (NP) had removed the eschar cap from the left heel wound prior to the resident being	F 0686	The Waters of Hartford City respectfully submits the following plan of correction as a credible allegation of compliance to the above-mentioned regulations F-686. Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of 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. Facility's date of alleged compliance is 3/1/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** F 686 SS=D Treatment/Services to Prevent/Heal Pressure Ulcer 1 It is the policy of The Waters of Hartford City to prevent the development of a pressure ulcers and review interventions to	03/01/2024

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	hospitalized on 1/19/24. During an observation on 2/7/24 at 2:09 p.m., the resident was lying in bed on her right side with a heel boot on her left leg and foot. During an observation on 2/8/24 at 8:27 a.m., the resident was sitting in her recliner with a heel boot on her left leg and foot. Her legs were elevated. Resident 32's clinical record was reviewed on 2/6/24 at 3:09 p.m. Her diagnoses included diabetes mellitus with diabetic neuropathy, obesity, muscle weakness, and dementia. Current physician's orders included: cleanse area on left heel, apply medical grade honey to wound, and cover with gauze then wrap with fluff dried pre-woven gauze daily until healed, float heels at all times when in bed every shift, and pressure reduction boot to left foot at all times, may remove for transfers every shift. A 1/15/24 minimum data set (MDS) assessment indicated the resident was moderately cognitively impaired. She required partial/moderate assistance of staff to roll from left to right. She required substantial/maximal assistance of staff for dressing her lower body. She was dependent on staff for transfers. She was at risk of developing a pressure injury and had an unstageable pressure injury with suspected deep tissue injury in evolution. A care plan problem, created on 10/15/23, revised on 1/25/24, indicated the resident had developed a deep tissue injury that presented as a dark purple intact blister to her left heel. (1/15/24 - wound NP removed eschar from wound) - returned from hospital on 1/25/24 with the area as unstageable		prevent pressure injuries. 2 The care plan and interventions for Resident #32 have been reviewed and updated. 3 All residents have the potential to be affected. The facility has reviewed all resident's skin and no other residents were found with any skin issues. The facility has also reviewed all pressure ulcer interventions, and none were found out of compliance. Facility reviewed preventive interventions, documentation, and care plans ensuring they updated accordingly by DON or designee on 2/23/2024. 4 The DON and ADON educated all nursing staff regarding interventions in place to prevent pressure ulcers including notifying the nurse of noncompliance with interventions and documentation. Any staff that fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. In-service was completed 2/21/24 see attendance log (Attachment D). 5 To ensure that this deficient practice does not re-occur the Quality Improvement Audit Tool "Pressure Prevention" (Attachment E) will be completed by the DON or designee for all residents with moderate / high risk for pressure ulcers. DON or designee will audit all residents for pressure ulcer	

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	(wound bed cannot be visualized to determine wound stage). A care plan problem, created on 7/1/23, revised on 9/28/23, indicated the resident was at risk for skin breakdown. Her diagnoses included diabetes, obesity, chronic heart disease, and incontinence and edema. She had no right great toenail. She slept in a recliner and preferred to not have a bed in her room. She was noncompliant at times with interventions even with education and encouragement. The same care plan problem was revised on 10/30/23 and indicated the resident was at risk for skin breakdown. Her diagnoses included diabetes, obesity, chronic heart disease, and incontinence and edema. She had no right great toenail. She slept in a recliner and preferred to not have a bed in her room. She was noncompliant at times with interventions even with education and encouragement. On 10/12/23, the resident was noncompliant with floating heels off of bed surface for more than a few minutes, and will pull pillow out from under feet and kick pillow onto floor. A skin and wound progress note, dated 10/15/23 at 4:14 p.m., indicated a one inch by two-inch red/purple blister was found on the resident's left heel. A skin and wound progress note, dated 10/16/23 at 11:36 a.m., documented by the Wound NP, indicated the resident was being seen for left heel blister concerns. The resident did not have good bed mobility and preferred to be left alone. The area to the left heel measured 3 centimeters (cm) length (L) by 4.5 cm width (W). The area was staged as a deep tissue injury and coded as a		interventions weekly x 4 weeks, then 10 residents weekly x 4 weeks, then 10 residents monthly x 4 months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the audit be reviewed. Any concerns will have been corrected as found, then logged on the Quality Improvement Summary Log (Attachment C). Any patterns will be identified. If necessary, an Action Plan will be written by the committee, any action plan will be monitored by the Administrator weekly until resolution is met. 6 All Systemic changes will be in place by 3/1/2024.	

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	pressure-induced deep tissue damage of the left heel. A skin and wound progress note, dated 11/13/23 at 4:28 a.m., documented by the Wound NP, indicated the wound status was stalled. The wound measurements were 4.5 cm L by 5.5 cm W. A skin and wound progress note, dated 12/18/23 at 8:08 a.m., documented by the Wound NP, indicated the wound measurements were 2.5 cm L by 2 cm W. A skin and wound progress note, dated 1/2/24 at 1:34 p.m., documented by the Wound NP, indicated the wound status was stable eschar. Removal of necrotic tissue was performed. Wound measurements were 2 cm L by 1 cm W. A skin and wound progress note, dated 1/15/24 at 2:22 p.m., documented by the Wound NP, indicated the wound was improving despite the measurements. Removal of necrotic tissue was performed. The wound measurements were 3 cm L by 1.5 cm W by 0.1 cm deep. A skin and wound progress note, dated 1/29/24 at 9:54 a.m., documented by the Wound NP indicated the wound staging was changed from deep tissue injury to unstageable following the recent hospitalization. Removal of necrotic tissue was performed. The wound measurements were 2.5 cm L by 2.5 cm W by 0.1 cm deep. A skin and wound progress note, dated 2/5/24 at a.m., documented by the Wound NP, indicated the wound was improving despite measurements and remained unstageable. The wound measurements were 1.0 cm L by 2.5 cm W by 0.1 cm deep.			

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	During an interview, on 2/9/24 at 8:39 a.m., CNA 5 indicated the resident's heels were floated. She wore heel boots. During an interview, on 2/9/24 at 11:32 a.m., LPN 6 indicated the resident wore a boot to her left foot and her heels were floated. During an interview, on 2/9/24 at 11:52 a.m., the DON indicated on a 10/12/23 24-hour report sheet, the nurse had documented the resident had kicked out her pillow from under her heels while in bed. She was unable to locate additional CNA or nurse documentation of the resident's noncompliance with interventions to prevent the development of pressure injuries. During an interview, on 2/9/24 at 12:44 p.m., the ADON indicated the resident had been sleeping in her recliner, then she began sleeping in her bed as she began in have increasing episodes of incontinence. She was uncertain of the date when the resident began sleeping in her bed. A facility policy, dated 5/20/23, titled "Guidelines for Preventative Skin Care," provided by the DON on 2/9/24 at 4:04 p.m., indicated " ...It is the intent of the facility to provide residents with preventive skin care through careful washing, rinsing and drying of their skin, to keep them clean, comfortable, well-groomed and free from pressure sores ...." 3.1-40(a)(1)			