STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/22/2024			
	PROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000							
Bldg. 00 F 0656 SS=E	Licensure Survey. Survey dates: Janu Facility number: 00 Provider number: 1002 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type Medicare: 5 Medicaid: 22 Other: 18 Total: 45 These deficiencies accordance with 41 Quality review com 483.21(b)(1)(3) Develop/Implement	reflect State Findings cited in 0 IAC 16.2-3.1. spleted Janaury 30, 2024.	F 00	000	Preparation and/or execution of this plan of correction in gener or this corrective action does reconstitute an admission of agreement by this facility of the facts alleged or conclusions see forth in this statement of deficiencies. The plan of corrective actions prepared and/or executed in compliance with State and Fee Laws. Facility's date of alleged compliance is February 20, 20. The facility is respectfully requesting paper compliance is all deficiencies in this POC.	ral, not e et ction are deral I 24.	
Bldg. 00	§483.21(b)(1) The implement a comp care plan for each the resident rights and §483.10(c)(3) objectives and tim resident's medical psychosocial need comprehensive as	rehensive Care Plans a facility must develop and brehensive person-centered a resident, consistent with set forth at §483.10(c)(2) , that includes measurable eframes to meet a , nursing, and mental and dis that are identified in the are plan must describe the					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	3	TITLE		(X6) DATE
Kimberly L	ocke			HFA			02/14/2024

Any defiency statement 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 disclodays 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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CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00	COMPLETED	
155617 B. WING	01/22/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD		
524 ANDERSON RD		
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECT	TION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
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		
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 F 0656 F656 Develop/Implement	nt 02/20/2024	
failed to ensure care plans had measurable goals Comprehensive Care Plan		

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and individualized approaches for 4 of 14

Event ID:

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What corrective action will be

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155617	B. WI	ING		01/22/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHESTERFIELD, IN 46017			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	residents reviewed for care plan development (Residents 44, 45, 4, and 19)				accomplished for those reside		
	(Residents 44, 45,	+, and 19)			found to have been affected b	y tne	
	Findings include: 1. Resident 44's clinical record was reviewed on 1/18/24 at 11:15 a.m. Current diagnoses included				deficient practice:		
					It is the policy of this facility to ensure care plans have		
					measurable goals and		
					individualized approaches.		
	anxiety disorder, insomnia, hypertension, malaise,				Resident #4, 19, 44 and 45 ca	are	
	-	ce of right leg above the knee.			plans were updated by Social		
	1				Services or designee on 2/17		
	An 11/2/23, quarterly, Minimum Data Set (MDS)				with measurable goals and		
	assessment indicated the resident had no				individualized approaches.		
	cognitive limitation, understood others and was						
	understood by others, and displayed no				How other residents having th	ie	
	-	iors during the assessment			potential to be affected by the		
	period.				same deficient practice will be		
					identified and what corrective		
		current, 11/2/23, care plan			action will be taken:		
	-	rding insomnia. The goal to			All residents that currently res		
	-	achieve 6-8 hours of restful			in the facility have the potential		
	sleep.				be affected by the alleged def	icient	
	Dumin : /	rr on 1/10/24 of 10:20 d			practice. The Social Service		
	_	v on 1/19/24 at 10:20 a.m., the			Director or designee will comp		
		signee (SSD) indicated the e a method to measure restful			a facility wide audit on 2/17/24		
	sleep.	c a method to measure restrui			update all current resident's c plans related to social service		
	ысер.				and behavior management wi		
	2. Resident 45's cl	inical record was reviewed on			measurable goals and	"1	
		m. Current diagnoses included			individualized approaches.		
		der, schizophrenia, depression,					
	and anxiety.	• • • • • • • • • • • • • • • • • • • •			What measures will be put in		
	•				place and what systemic char	nges	
	An 11/29/23, admis	ssion, Minimum Data Set (MDS)			will be made to ensure that th	-	
	assessment indicate	ed the resident had no			deficient practice does not red	cur:	
	_	ns, had self-reported moderate			The Administrator educated the	ne	
	-	good others and was			Social Service Director on 2/1	3/24	
	•	rs, used antipsychotic/			on the care plan process and		
	_	antianxiety medications daily,			the facility's behavior manage	ment	
	-	portant to make decisions about			system. Additionally, any		
	her daily life, and displayed no maladaptive				employee who fails to comply	with	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/22/2024 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE behaviors during the assessment period. the points of the in-service may be further educated and/or The resident had a current, 11/28/23, care plan progressively disciplined as problem/need regarding at risk for behavioral indicated. disturbance due to a diagnosis of schizophrenia. A goal for this problem was the resident will have no episodes of behavior related to the diagnosis daily. The identified behaviors associated with the resident's schizophrenia were not identified in How the corrective action will be the care plan or within the resident's clinical monitored to ensure the deficient record. The goal was not assessed to identify if practice will not recur. i.e what the resident displaying "no episodes" of the major quality assurance program will be mental illness schizophrenia was an obtainable or put into place: a medically appropriate goal. The "F656 - Develop and Implement Comprehensive Care The resident had a current, 11/25/23, care plan Plan Audit" will be completed on 5 problem/need regarding a diagnosis of bipolar random residents weekly for 4 disorder. A goal for this problem was the resident weeks, on 3 random residents will be free from signs and symptoms of bipolar weekly for 4 weeks, and 3 random disorder. residents monthly x3 months. If The identified behaviors associated with the the facility is within 95% resident's bipolar disorder were not identified in compliance at the end of the 6 the care plan or within the resident's clinical months; then monitoring can be record. The goal was not assessed to identify if stopped. Results of the monitoring the resident displaying "no episodes" of the major will be reviewed at the monthly mental illness bipolar disorder was an obtainable QAPI meeting. Any concerns will or medically appropriate goal. have been addressed. However, any patterns will be identified. Any The resident had a current, 11/28/23, care plan needed Action Plan will be written problem/need regarding a diagnosis of depression by the QAPI committee. Any and a risk of decline in mood. The goal for this written Action Plan will be problem was to have no "decline in mood" daily. monitored by the Administrator How to identify a "decline in mood" associated weekly until resolved. with depression was not listed in the care plan or in the clinical record. The resident had a current, 11/25/23, care plan problem/need regarding the potential to express By what date the systemic

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signs and symptoms of anxiety. The goal for this

problem was "Resident will verbalize feelings

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completed.

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changes for each deficient will be

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	I OF HEALTH AND HU R MEDICARE & MEDIC		FORM APPROVEI OMB NO. 0938-039				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/22/2024				
	PROVIDER OR SUPPLIEF	LD SKILLED NURSING FACILIT	Υ	524 AN	ADDRESS, CITY, STATE, ZIP COD IDERSON RD ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	appropriately and we coping behaviors." address the resident psychiatric services record lacked defin "verbalize feeling a effective copying behaviors." During an interview Director of Nursing and Social Services p.m., the Administr of care lacked mear the resident's goals. 3. Resident 4's clin 1/17/24 at 11:33 a. a. Alzheimer's disease anxiety disorder, and A 12/16/23, quarter assessment indicate cognitive limitation understood by other depression, received antianxiety medicate medication daily, and medications during The resident had a deproblem/need regar to dementia. An app "Unless hard of head tone. This approach."	The care plan did not It's decline to use in house The care plan and clinical ition of how the resident would ppropriately" or "demonstrate ehaviors." Whith the Administrator, Assistant Director of Nursing Designee on 1/19/24 at 3:45 ator indicted Resident 45's plan as to define the ability to reach Current diagnosis included Asymptotic medication, and unspecified psychosis. The Minimum Data Set (MDS) and the resident had mild asymptotic medication, and antidepressant and displayed no maladaptive the assessment period. Current, 5/31/22, care plan ding cognitive impairment due proach to this problem was uring" talk softly in a normal a originated 2/28/22.			February 20, 2024		
	problem was, "will	accept reassurance during					

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intervention."

periods of anxiety upon immediate staff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 01/22/2024				
		155617	B. WING	<u> </u>		01/22/	/2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			DERSON RD ERFIELD, IN 46017		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
	The regident had a	current, 6/23/22, care plan					
		ding "attention seeking." A					
		was, "I will have a reduction					
		pulative behaviors."					
		. 2/12/22					
		current, 3/13/23, care plan ding mood decline due to					
		to this problem was "Will					
	have no decline in r	•					
	The resident had a current, 3/13/23, care plan						
	problem/need regarding a risk of behavioral						
	disturbances related to a psychotic disorder. A goal to this problem was to have no episodes to						
	behavior related to	-					
	condition related to	ans diagnosis.					
	The resident had a c	current 3/13/23, care plan					
	-	ding anxiety. A goal for this					
	-	e a decline in episodes of					
	anxious behavior.						
	During an interview	on 1/19/24 at 3:45 p.m., the					
	-	ated the above goals were not					
	measurable or well	defined. Approaches should					
	· ·	uch as the facility should be					
	aware if the residen	t could hear.					
	4. Resident 19's clir	nical record was reviewed on					
		.m. Current diagnosis included					
		ajor depressive disorder, and					
	diabetes mellitus.						
	A 12/2/23 quarterly	y, Minimum Data Set (MDS)					
		d the resident did not have					
		s, had self-reported moderate					
	depression, understo						
		rs, received an antidepressant					
		played no maladaptive					
	behaviors during the	e assessment period.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		A. BUILDING <u>00</u> COMPI		E SURVEY PLETED 2/2024					
	PROVIDER OR SUPPLIER S OF CHESTERFIE	LD SKILLED NURSING FACILIT	524 AN	STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
	problem/need regar The goal for this pr	current, 3/1/23, care plan ding a diagnosis of bipolar. oblem was to be free of signs ipolar and depression.							
	problem regarding a problem was to den	current, 3/1/23, care plan anxiety. The goal for this nonstrate increased control iors as evidenced by [left d information].							
	Director of Nursing and Social Services p.m., the Administr be blanks in the car	w with the Administrator, g, Assistant Director of Nursing Designee on 1/19/24 at 3:45 ator indicated there should not e plan, the goals, or the sidents goals were not							
	"Baseline Care Plan Care Plan", which was Administrator in 1/2 "using the 'Persor	facility policy, titled n Assessment/ Comprehensive was provided by the 22/24 at 12:57 p.m., indicated: n Centered' plan of care esident that includes yes"							
	3.1-35(a)								
F 0657 SS=E Bldg. 00	§483.21(b)(2) A c must be- (i) Developed with of the comprehen	and Revision rehensive Care Plans omprehensive care plan in 7 days after completion sive assessment. n interdisciplinary team, that t limited to							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/22/2024 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility F 0657 02/20/2024 F657 Care Plan Timing and failed to review and revise care plans for 1 of 14 Revision resident reviewed for care plan revision (Resident What corrective action will be accomplished for those residents found to have been affected by the Findings include: deficient practice: It is the policy of the facility that Resident 4's clinical record was reviewed on the facility will review and revise 1/17/24 at 11:33 a.m. Current diagnosis included comprehensive care plans, Alzheimer's disease, major depressive disorder, quarterly, annually and with anxiety disorder, and unspecified psychosis. change in conditions as needed.

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A 12/16/23, quarterly, Minimum Data Set (MDS)

cognitive limitations, understood others and was understood by others, had moderate self-reported

depression, received antipsychotic medication,

medication daily, and displayed no maladaptive

assessment indicated the resident had mild

antianxiety medication, and antidepressant

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Resident #4 care plans were

revised on 2/17/24 related to

How other residents having the

potential to be affected by the

same deficient practice will be

identified and what corrective

behavior management.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
						` '		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED		
		155617	B. WING 01/22/2024					
NAME OF P	ROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD			
			524 ANDERSON RD					
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	medications during	the assessment period.			action will be taken:			
					All residents that currently res			
		current, 5/31/22, care plan			in the facility have the potentia			
	-	ding cognitive impairment due			be affected by the alleged def	icient		
	to dementia.				practice. The Social Service			
		each to this visit was for the			Director or designee complete			
		and as needed. This			facility wide audit on 2/17/24 to			
	approach originated	1 2/28/22.			update all current resident's ca	are		
					plans related to behavior			
		current, 2/27/22, care plan			management.			
	problem/need depression, which contained a							
	6/23/22 note which indicated the resident stated				What measures will be put in			
	she would be better off dead. An approach to this				place and what systemic chan	_		
	problem was ""Fifte	een minutes checks (11/22/22)".			will be made to ensure that the			
					deficient practice does not rec			
		current, 5/31/22, care plan			The Administrator educated th			
	-	arding anxiety. An approach to			Social Service Director on 2/1			
	this problem was "O	Offer talk therapy"			on the care plan process and			
					the facility's behavior manage	ment		
	_	w with the Administrator,			system. Additionally, any			
	_	g, Assistant Director of Nursing			employee who fails to comply			
		Designee on 1/19/24 at 3:45			the points of the in-service ma	ıy be		
	_	rator indicated the above care			further educated and/or			
		d not been reviewed and			progressively disciplined as			
		l Service Director indicated she			indicated.			
		weekly visit. All three						
	_	the psychiatric services						
	-	d not provided services in the						
	facility for years.							
					How the corrective action will			
		facility policy, titled			monitored to ensure the defici			
		n Assessment/ Comprehensive			practice will not recur, i.e wha			
	Care Plan", which v	-			quality assurance program wil	l be		
		22/24 at 12:57 p.m., indicated:			put into place:			
		emains in the Nursing Home,			The "F657 - Care Plan Timing			
	_	will be made to the resident's			Revision Audit" will be comple			
		Comprehensive Care Plan will be			on 5 random residents weekly	for		
	reviewed and updat	ed every quarter"			4 weeks, 3 random residents			
					weekly for 4 weeks, and 3 ran			
	3.1-35(e)				residents monthly for 3 month	s. If		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2024 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017 ID PROVIDERS PLAN OF CORRECTION TO REPORT OF THE PROVIDERS PLAN OF CORRECTION TO REPORT OF THE PROVIDERS PLAN OF CORRECTION TO REPORT OF THE PROVIDERS PLAN OF CORRECTION TO PROVIDERS	(X3) DATE SURVEY COMPLETED 01/22/2024	
PROVIDER'S PLAN OF CORRECTION		
CROSS-REFERENCED TO THE APPROPRIATE	(X5) PLETION ATE	
the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. 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. By what date the systemic changes for each deficient will be completed. Tebruary 20, 2024 William Agents and the systemic changes for each deficient will be completed. Tebruary 20, 2024 William Agents and the systemic changes for each deficient will be completed. Tebruary 20, 2024 William Agents and the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Tebruary 20, 2024 William Agents and the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be monitored by the Administrator weekly until resolved. By written by the Administrator weekly until resolved. By		

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Event ID:

RI9F11

Facility ID: 000524

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLET			LETED
		155617	B. WING 01/22/2024				
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			IDERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.25(g)(3) Is offered a therapeutic diet						
		utritional problem and the					
	Based on record rev	er orders a therapeutic diet.	EA	· 0.2	ECO2 Notwition/Unidention Cta	.4	02/20/2024
		ility failed to assess a resident	F 06	92	F692 Nutrition/Hydration Sta	สเนร	02/20/2024
		al decline and weight loss and			What corrective action will be		
		weight loss interventions for 1				nte	
	_	_			accomplished for those reside found to have been affected b		
	of 3 resident reviewed for nutrition. (Resident 27)				deficient practice:	y u ie	
	Findings include:				It is the policy of the facility to		
	i manigo metade.				assess residents at risk for		
	The clinical record for Resident 27 was reviewed				nutritional decline and weight	loss	
	on 1/17/24 at 2:43 p.m. Diagnosis included				and to implement weight loss		
	nontraumatic subdural hemorrhage, essential				interventions as needed. Res	ident	
		Alzheimer's disease with early			#27 was assessed on 2/12/24		
	onset.	•			nutritional declines and weigh		
					loss interventions were		
	Current physician's	orders included pureed diet			implemented.		
	(may have oatmeal)	(4/23/21) and house shake					
	with meals for supp	element- Give one			How other residents having th	е	
	container/serving by	y mouth, record percentage			potential to be affected by the		
	consumed (1/26/23)).			same deficient practice will be	:	
					identified and what corrective		
		thly weight record indicated			action will be taken:		1
	the following:				All residents that currently res		1
					in the facility have the potentia		
	On 9/6/23 the reside	ent weighed 131.6 pounds.			be affected by the alleged def		
	0 10/1/22 1	1			practice. The Director of Nursi	-	
	On 10/1/23 the resid	dent weighed 132.1 pounds.			or designee completed a facili	-	
	O. 1/5/24/1 11				wide audit on 2/12/24 to verify		
		ent weighed 117.0 pounds. (A			current residents have up-to-d		
		since the resident's last			monthly/weekly weights and the		
	recorded weight 3 r	понив риог.)			all weight concerns are address	ssea	1
	The monthly waich	t record lacked a weight for			by the Physician or Nurse	ngor	
	November 2023 and	C			Practitioner. The Dietary Mana	-	
	140vember 2023 and	d December 2023.			or designee completed a facili wide audit on 2/12/24 to verify	-	
	The resident's clinic	cal record lacked a dietary			current residents have up-to-d		
		he had resumed monthly			dietary progress notes, verify	ıal C	
					physician orders for prescribe	d	
	weights in Septemo	weights in September 2023, after hospice services			physician orders for prescribe	u	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
			A. BUILDING 00			· ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	B. WING			COMPLETED 01/22/2024	
		155617	В. W.	ing		01/22/	ZUZ4
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were discontinued.				diet and supplements, update	tray	
					card system, and ensure that		
	A current nutrition risk care plan, updated 8/11/23,				nutrition care plans are update	ed	
		nt was at increased risk of			and are current with physician	1	
		are plan interventions included			orders.		
	the following: 2 Ca	l (a nutritional supplement) with					
	meals, Remeron (ar	n antidepressant) for appetite			What measures will be put in		
	stimulant, and mon	itor weights.			place and what systemic chan	iges	
					will be made to ensure that the	e	
	_	y, on 1/19/23 at 9:30 a.m., the			deficient practice does not rec	ur:	
	DON indicated the resident recently been						
	removed from hospice services and weights were				The Administrator educated th	ne	
	re-started when this	occurred in August. She was			Director of Nursing and Dietar	у	
	not able to locate w	eights taken in November			Manager on 2/13/24 on the ca	ire	
	2023. The facility h	ad a COVID-19 outbreak in			plan process related to nutritic	on,	
	December 2023 and	d there were no weights taken			weight management program, and		
	for residents during	that month. The resident's			on dietary tray card usage. Th		
	weight loss was dis	covered with the weight taken			Administrator educated the fac	cility	
	on January 5th, 202	4.			staff on 2/13/24 the weight		
					management program and die	etary	
	During an observati	ion and interview, on 1/22/24			card usage. Additionally, an	y	
	at 1:11 p.m., Reside	ent 27 was seated in the			employee who fails to comply	with	
		isted with his meal by a			the points of the in-service ma	ıy be	
	nursing staff memb	er. The lunch plate contained			further educated and/or		
	_	mashed potatoes. There was			progressively disciplined as		
		fruit punch and one cup			indicated.		
		resident meal card indicated a			How the corrective action will	be	
	_	symbols (a picture of			monitored to ensure the defici	ent	
		etter S on a cup) printed at the			practice will not recur, i.e wha	t	
	_	ed across from Resident 27,			quality assurance program wil	l be	
		ot sure what the symbols on			put into place:		
	the top of this meal	card meant.			The "F692 – Nutrition/Hydration	on	
					Status Maintenance Audit -		
	_	v on 1/22/24 at 1:13 p.m., the			Nursing" will be completed on		
		dicated the symbols at the top			random residents weekly for 4		
		ated any specialty items to be			weeks, 3 random residents we	-	
		meal. The letter S on the cup			for 4 weeks, 3 random resider		
		nt was to receive a supplement			monthly for 3 months. The "F6	892 –	
	with this meal.				Nutrition/Hydration Status		
					Maintenance Audit – Dietary"	will	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155617	B. W	ING		01/22/	/2024
	PROVIDER OR SUPPLIERS	LD SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 524 ANDERSON RD CHESTERFIELD, IN 46017				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.0	DATE
	p.m., the DON indi pre-packaged house making those indiv During an interview DON indicated ther loss or nutrition pol Skin and Weight A Program, to manag program was a mee	interview on 1/22/24 at 2:30 cated the facility had run out of a shakes and the kitchen was idually for residents. It is, on 1/19/24 at 11:42 a.m., the re was not a specific weight licy, and the facility utilized the assessment Team, or S.W.A.T. we weight concerns. This ting to review the clinical repotential issues or situations all resident appetite.			be completed 5x weekly for 4 weeks, 2x weekly for 4 weeks then 1x weekly for 4 months. I facility is within 95% complian at the end of the 6 months; the monitoring can be stopped. Results of the monitoring will I reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, an patterns will be identified. Any needed Action Plan will be wriby the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will completed. February 20, 2024	If the ce en be ve by ritten	
F 0745 SS=E Bldg. 00	§483.40(d) The farmedically-related maintain the higher mental and psych resident. Based on observation review, the facility social services to remajor mental illness monitoring, behavior plans, and provision mental and behavior	cally Related Social Service acility must provide social services to attain or est practicable physical, osocial well-being of each on, interview, and record failed to offer medically related esidents with a diagnosis of a s in relation to behavior or management, updating care of personalized care for oral health for 4 of 4 residents sion of medically related social 44, 45, 4 and 19)	F 0'	745	F745 Provision of Medically Related Social Services What corrective action will be accomplished for those reside found to have been affected b deficient practice: It is the policy of the facility that the facility must provide medic related social services to attai	ents y the at cally	02/20/2024

maintain the highest practicable

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155617	B. W	B. WING 01/22/2024			/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8					
\\\∆T⊏D¢	OF CHESTEREIE	LD SKILLED NURSING FACILITY		524 ANDERSON RD CHESTERFIELD, IN 46017			
WAIERS	OI GHESTERFIE	LE SKILLED NORSING FACILITY		CHEST	LIGIELD, IN 40017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				physical, mental and psychoso		
					well-being of each resident. C		
	1. During a resident group interview on 1/17/24 at				plans for residents #4, 19, 44,		
	10:30 a.m., Resident 44 indicated he suffered from				45 were updated on 2/17/24 to		
	insomnia and liked to sleep whenever he can.				indicate medically related soci	al	
	Staff woke him up for showers and such. When				service needs and behavior		
	he said no he'd rath	er sleep, they say he refused			monitoring.		
	care.						
					How other residents having th	е	
	During an interview on 1/22/23 at 11:08 a.m.,				potential to be affected by the		
	Resident 44 indicated he had never told the				same deficient practice will be		
	facility he wanted to sleep at night. He had told				identified and what corrective		
	the facility he wanted to sleep whenever he could				action will be taken:		
	sleep.				All residents that currently res		
					in the facility have the potentia		
		al record was reviewed on			be affected by the alleged defi	cient	
		m. Current diagnosis included		practice. The Social Service			
	•	somnia, hypertension, malaise,			Director or Designee complete		
	and acquired absence	ce of right leg above the knee.			facility wide audit on 2/17/24 to		
	4 10/20/22 HG :	10 · F 1 · ' "			verify that all current residents		
		ll Services Evaluation"			have a diagnosis of a major m		
		nt desired to return home with			illness, require personalized c		
	home health after re	enabilitation.			for mental or behavioral health		
	The January 2024"	Tuestment Administration			require Behavior Managemen	l	
		Treatment Administration he resident had behavior			Services are identified.		
		ift for "anxiety", "ineffective			M/b at magazines will be mut in		
	_				What measures will be put in	300	
		"resistance to care". Resident			place and what systemic chan	-	
	_	n describing what behavioral			will be made to ensure that the		
		ent displayed when anxious or ive copying skills" were not			deficient practice does not rec		
		., .			The Administrator educated the		
		avior monitoring record. Ten ect the monitored behaviors			Social Service Director on 2/1		
	* *	ehavior monitoring record.			on identifying diagnoses of ma mental illness, on resident's th	-	
		re not resident specific and			'	ıal	
	* *	•			require personalized care for	r	
		empt redirection, snack, fluid diversion, toileting, change in			mental or behavioral health, o		
					residents that require Behavio	ſ	
	_	assessment, offer nap/rest			Management Services.	_	
		nfort measures, and "other"			Additionally, any employee wh		
1	with no resident spe	ecific approaches listed.	l		fails to comply with the points	OĪ	I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155617	B. W	ING		01/22	/2024
				CENTER	ADDRESS STEV STATE SID SOD		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD DERSON RD		
\A/A TED C	OF CHECTEREIS	LD CKILLED NUIDCING FACILITY					
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the in-service may be further		
	An 11/2/23, quarter	ly, Minimum Data Set (MDS)			educated and/or progressively	/	
	assessment indicate	d the resident had no			disciplined as indicated.		
	cognitive limitation	, understood others and was					
	understood by other						
	maladaptive behavi	ors during the assessment					
	period.						
					How the corrective action will		
		current, 11/7/23, care plan			monitored to ensure the defici		
	-	ding displayed behavioral			practice will not recur, i.e wha		
		o: poor and/or ineffective			quality assurance program wil	ll be	
		fested by refusal of care. The			put into place:		
		ehavior management program.			The "F745 - Provision of Medi	-	
		th to this problem was to			Related Social Services Audit	" will	
		tion of behavioral symptom(s)			be completed on 5 random		
		trengths, abilities & needs are			residentsweekly for 4 weeks,		
	communicated via t	the behaviors."			random residents weekly for 4		
	and the state	. 11/0/00			weeks, and 3 random residen		
		current, 11/2/23, care plan			monthly for 3 months. If the fa	-	
	-	ding insomnia. The goal to			is within 95% compliance at the	ne	
	-	achieve 6-8 hours of restful			end of the 6 months; then		
		to this problem included to			monitoring can be stopped.	L -	
		ent not to take naps during			Results of the monitoring will I		
	the day.				reviewed at the monthly QAPI		
	During an interview	on 1/18/24 at 3:40 p.m., the			meeting. Any concerns will ha been addressed. However, ar		
		ated many of the care plans			patterns will be identified. Any	•	
		personalized and did not have			needed Action Plan will be wri		
	measurable goals.	personanzed and did not have			by the QAPI committee. Any	iucii	
	measurable goals.				written Action Plan will be		
	During an interview	on 1/19/24 at 10:20 a.m., the			monitored by the Administrato	nr	
		signee (SSD) indicated the			weekly until resolved.	••	
		ior monitoring system, but she					
		ehavior management plan for			By what date the systemic		
		ad a list of residents who			changes for each deficient wil	l be	
	•	nonitoring. There were not			completed.		
	-	proaches to managing the			February 20, 2024		
		not keep a system that					
		pehavioral events or the dates					
	_	e displayed. There was not a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155617	B. WI	NG		01/22	/2024	
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	2			DERSON RD			
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017			
(VA) ID	OTD D (1777)	OTA TEMENT OF DEPLOYED OF	T	Ц	•		avs.	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION ated resident specific		TAG	DEFICIENCE!		DATE	
	1 -	age behaviors. She had not						
		ation of the resident's sleeping						
		or spoken to him about it. She						
	1 ~	ent to bed at night and arose in						
		at home. She had not						
	completed a behavious	oral evaluation as mentioned						
	in the plan of care.							
		nical record was reviewed on						
		n. Current diagnosis included						
		der, schizophrenia, depression,						
	and anxiety.							
	A 12/27/22 DAGAD	R Level II report indicated the						
		p thinking through and						
		time and need supportive						
	counseling services							
	An 11/29/23, "Socia	al Service Evaluation",						
	indicated the resider	nt was alert and oriented, and						
	had been admitted t	to the facility for planned long						
		ne resident desired a short term						
	1 ~	living with her family, and						
		als needed to be addressed						
	during the next care	e plan meeting.						
	A !!Comacint for C	viocall forms in directs dela-						
		vices" form indicated the						
		house psychiatric services on lent had previously seen a						
		provider when living at home.						
		at the facility would be short						
		return to her previous						
	provider upon disch	-						
	The current January	2024 "Treatment						
	Administration Rec	ord" indicated the resident had						
		g each shift for "anxiety",						
		ulness", "self isolation", and						
	"resistance to care".	Resident specific						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RI9F11

Facility ID: 000524

If continuation sheet Page 16 of 25

IDENTIFICATION NUMBER 15617 NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY (V4) ID SLIMMARY STATIMIST OF DEPICINCIL TAG RECOLLATORY OLS LEDENTIFYEN DEPOCHMENT TAG RECOLLATORY OLS LEDENTIFYEN DEPOCHMENT TAG RECOLLATORY OLS LEDENTIFYEN DEPOCHMENT THE recident displayed when amoiss or depressed was not included in the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches depressed was not included in the behavior monitoring record. The approaches of redirect the resident specific and were as follows: attempt redirection, stack, fluid offered, activity for diversion, toileting, change in environment, plant assessment indicated the resident shall no cognitive limitations, had self-reported moderate depression, understood obters and was understood by others, used antipsychotic/ antidepressant and undamariety medications duily, believed it was important to make decisions about her daily life, and displayed no maladaptive behaviors during the assessment period. The resident had a current, 11/28/23, care plan problem/need regarding at risk for behavioral disturbance due to a diagnosis of schizophrenia. The record The gad was "no episodes" of the major mental filmess schizophrenia. The record lacked an assessment as to whether this was an obtainable or a medically appropriate goal. The resident had a current, 11/28/23, care plan problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resi	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY (X4)ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SERGILATORY OR ISE DIDINIFING MINORMATION information describing what behavioral symptoms the resident displayed when auxious or depressed was not included in the behavior monitoring record. Ten approaches to redirect the monitored behaviors were listed on the behavior monitoring and "other" with no resident specific approaches listed. An 11/29/23, admission, Minimum Data Set (MDS) assessment indicated the resident selection disease, and "other" with no resident specific approaches listed. An 11/29/23, admission, Minimum Data Set (MDS) assessment indicated the resident solution and was understood by others, used antipsychotic/ antidepressant and antiaxiety medications daily, believed it was important to make decisions about her daily life, and displayed no maladaptive behaviors during the assessment of selection was the resident will have no episodes of behavior related to the diagnosis daily. The identified behaviors associated with the resident's schizophrenia. A goal for this proble havior related to the diagnosis daily. The identified behaviors associated with the resident's schizophrenia. The record lacked an assessment in a more pisodes of the major mental illness schizophrenia. The record lacked an assessment is whether this was an obtainable or a medically appropriate goal. The resident had a current, 11/25/23, care plan problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resident solution and obtainable or a medically appropriate goal.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY WATERS OF CHESTERFIELD SKILLED NURSING FACILITY IN SUMMARY STATEMENT OF DEFICIENCE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION information describing what behavioral symptoms the resident displayed when anxious or depressed was not included in the behavior monitoring record. Ten approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The improaches to redirect the monitored behaviors were listed on the behavior monitoring record. The improaches were not resident specific and were as follows: attempt redirection, snack, fluid offered, activity for diversion, (solieting, change in environment, pain assessment, offer appress period, provide comfort measures, and "other" with no resident bad no cognitive limitations, had self-reported moderate depression, understood others and was understood by others, used antipsychotic/ antidepressant and antianxiety medications daily, believed it was improatant to make decisions about her daily life, and displayed no maladaptive behaviors during the assessment period. The resident had a current, 11/28/23, care plan problem/need regarding at risk for behaviors and an assessment as to seek the properties of the major mental illness schizophrenia. The resident had a current, 11/28/23, care plan problem/need regarding at diagnosis of bipolar disorder. A goal for this problem was the resident			155617	B. WING		01/22/2024	
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obtainable or a medically appropriate goal. The resident had a current, 11/25/23, care plan problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resident			-				
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problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resident			-				
disorder. A goal for this problem was the resident		The resident had a	current, 11/25/23, care plan				
will be free from signs and symptoms of bipolar							
,		will be free from sig	gns and symptoms of bipolar				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	lG	00	COMPL	ETED
		155617	B. WING			01/22/	/2024
			STI	REET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY			ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	Ĵ	DEFICIENCY)		DATE
		tified behaviors associated					
		pipolar disorder were not					
		e plan or within the resident's					
		e goal was not assessed to					
		ent displaying "no episodes" illness bipolar disorder was an					
	-	ally appropriate goal.					
	ootamadie di medic	any appropriate goat.					
	The resident had a c	current, 11/28/23, care plan					
		ding a diagnosis of depression					
		e in mood. The goal for this					
		e no "decline in mood" daily.					
	-	decline in mood" associated					
	with depression was	s not listed in the care plan or					
	in the clinical record	d.					
		44/07/00					
		current, 11/25/23, care plan					
	-	ding the potential to express					
		s of anxiety. The goal for this					
	-	dent will verbalize feelings vill demonstrate effective					
		An approach to this problem					
		dent to mental health services					
	•	on with psychiatrist and					
	_	ices. The care plan did not					
		's decline to use in house					
		. The resident's clinical record					
	* *	how to "verbalize feeling					
		lemonstrate effective copying					
	behaviors."						
	_	with the Administrator,					
	_	, Assistant Director of Nursing					
		Designee on 1/19/24 at 3:45					
		they were not aware of the					
		specific behavioral signs and					
		y and depression, or if the goal					
		ptoms" of schizophrenia was					
	medically appropria	ate for Resident 45.					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155617	B. WII	NG		01/22	/2024
		<u>l</u>	<u> </u>	CTDEET 4	ADDRESS, CITY, STATE, ZIP COD	<u>I</u>	
NAME OF F	PROVIDER OR SUPPLIER	8			DERSON RD		
\A/A TED	OF CHECTERIE	LD CKILLED MUDCING EACH ITV					
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	No information reg	arding care planning, social					
	services, and psych	osocial needs was provided					
	by the time of exit of	on 11/21/23 at 2:30 p.m.					
	3. During an intervi	iew on 1/17/24 at 10:15 a.m.,					
	Resident 4 indicated	d she often times was down or					
	blue.						
	Resident 4's clinica	l record was reviewed on					1
	1/17/24 at 11:33 a.r	n. Current diagnosis included					
	Alzheimer's disease	e, major depressive disorder,					
	anxiety disorder, an	nd unspecified psychosis.					
	A 12/16/23, quarter	ly, Minimum Data Set (MDS)					
	assessment indicate	d the resident had mild					
	cognitive limitation	s, understood others and was					
	understood by other	rs, had moderate self-reported					
	depression, received	d antipsychotic medication,					
	antianxiety medicat	ion, and antidepressant					
	medication daily, as	nd displayed no maladaptive					
	medications during	the assessment period.					
	The resident had a	current, 5/31/22, care plan					
	problem/need regar	ding cognitive impairment due					
	to dementia. An ap	proach to this problem was					
	"Unless hard of hea	ring" talk softly in a normal					
	tone. An additional	approach to this visit was for					
	the SSD to visit we	ekly and as needed. These					
	approaches originat	red 2/28/22.					
	The resident had a	current, 2/27/22, care plan					
	problem/need depre	ession, which contained a					
	6/23/22 note which	indicated the resident stated					
	she would be better	off dead. Approaches to this					
	problem included, "	Fifteen minutes checks					
	(11/22/22)".						
	The resident had a	current, 5/31/22, care plan					
		arding anxiety. A goal to this					
		accept reassurance during					

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ′		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 01/22/2024	
		155617	B. WI	ING		01/22	/2024
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
\\/\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	S OF CHESTERFIE	LD SKILLED NURSING FACILITY	,		DERSON RD ERFIELD, IN 46017		
	Т		<u> </u>		LIMILLO, IN TOUT		T
(X4) ID		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		pon immediate staff					
	1 -	approach to this problem was					
	"Offer talk therapy	care as allowed or desired."					
	The resident had a	current, 6/23/22, care plan					
		ding "attention seeking." A					
		n, "I will have a reduction in					
	episodes of manipu						
	<u> </u>						
		current, 3/13/23, care plan					
		ding mood decline due to to this problem was "Will					
	have no decline in r	-					
	have no deenne in i	nood dany.					
	The resident had a	current, 3/13/23, care plan					
	problem/need regar	ding a risk of behavioral					
		l to a psychotic disorder. A					
		n was to have no episodes to					
	behavior related to	this diagnosis.					
	The resident had a	current 3/13/23, care plan					
		ding anxiety. A goal for this					
	problem was to hav	e a decline in episodes of					
	anxious behavior.						
	Resident 4 was obse	erved in her room, watching					
		sitors, and interacting with her					
	_	24 at 9:37 a.m., 1/17/24 at 1:46					
	p.m., and 1/18/24 at						
	During on interview	y on 1/10/24 at 3:45 n m tha					
		on 1/19/24 at 3:45 p.m., the ated approaches for 2022					
		and revised with care plan					
		nt was not on 15-minute checks					
		1 15 minute checks since 2022.					
		ould be measurable and many					
		l which were discussed could					
	not be measured. C						
	personalized to the	resident and should identify					
	such issues as if the	resident could hear.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155617	B. W	ING		01/22/	/2024
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WATER	OF CHECTEDEIE	LD CKILLED MUDCING EACH ITY			DERSON RD		
WATERS	OF CHESTERFIE	LD SKILLED NURSING FACILITY		CHEST	ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	No information rega	arding care planning, social					
	services, and psycho	osocial services were					
	provided by the tim	ne of exit on 11/21/23 at 2:30					
	p.m.						
	4. Resident 19's clir	nical record was reviewed on					
		.m. Current diagnosis included					
		ajor depressive disorder, and					
	diabetes mellitus.						
		y, Minimum Data Set (MDS)					
		ed the resident did not have					
	_	s, had self-reported moderate					
	depression, understo						
	_	rs, received an antidepressant					
		played no maladaptive					
	behaviors during the	e assessment period.					
	A 1/11/24 DACAD	D. I1 II (4)4 - 4 4b -					
		R Level II report indicated the					
		e remembering things and					
		g decisions, does not really thing but visits with family					
	_	ed supportive counseling from					
	nursing home staff.						
	nursing nome starr.						
	The resident had a c	current, 3/1/23, care plan					
		ding a diagnosis of bipolar.					
		oblem was to be free of signs					
		ipolar and depression.					
	and symptoms of of	and depression.					
	The resident had a c	current, 3/1/23, care plan					
		anxiety. The goal for this					
		nonstrate increased control					
	•	iors as evidenced by [left					
		d information]. An approach					
		uded teaching the resident					
	•	gement techniques including					
	meditation or relaxa						
	UI						
			1				1

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	OF CORRECTION	IDENTIFICATION NUMBER 155617	A. BUILDING B. WING	00	COMPL: 01/22/	ETED
	ROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY	524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	1/17/24 at 1:36 p.m.	sting quietly in his room on and 1/18/24 at 9:27 a.m.				
	Director of Nursing and Social Services p.m., they indicated Resident 19's specidepression were, if a measurable and ac	with the Administrator, Assistant Director of Nursing Designee on 1/19/24 at 3:45 they would check into what fic signs of bipolar and no signs of these diseases was chievable goal, and what es the resident used.				
	No additional inforr time of exit on 11/2	nation was provided prior to 1/23 at 2:30 p.m.				
	"Behavior Monitori: 1/19/23 at 10:09 a.n	facility document titled ng" provided by the SSD on n., indicated "All new admits havior Monitoring log on				
	Service Behavioral SSD on 1/19/24 at 1 Social Service team Care and Social Ser AssessmentMood problemsBehavior	ral Management ProgramThe eworker will update the care				
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Ap Temp §483.60(d) Food a	pear, Palatable/Prefer and drink eives and the facility				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155617		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/22/2024					
	PROVIDER OR SUPPLIER	LD SKILLED NURSING FACILITY		524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	§483.60(d)(1) Foo conserve nutritive appearance; §483.60(d)(2) Foo palatable, attractive appetizing temper Based on observation review, the facility palatable for 5 of 5 Resident Council graph of the palatable for 5 of 5 Resident Council graph of the palatable for 5 of 5 Resident Council graph of the palatable for 5 of 5 Resident Council graph of the palatable for 5 of 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for the palatable for 5 p.m., one hall and sent to the halls of the palatable for the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for the halls of the palatable for the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of the palatable for 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent to the halls of 5 p.m., one hall and sent	od prepared by methods that value, flavor, and od and drink that is ve, and at a safe and ature. On, interview, and record failed to ensure food was residents interviewed in the roup interview. ce observation on 1/16/24 at a tray cart had been prepared of for distribution. on 1/16/24 at 12:10 p.m., the licated he had forgotten to take perfore serving the meals. with the Resident Council group a.m., the following food are expressed: cated hot food was served week or more. The food being only able to eat. cated vegetables were shy three times a week or ident indicated they did not eat effore did not have an opinion. cated the food was bland, flat ree times a week or more.	F 08		F804 Nutritive Value/Appea Palatable/Prefer Temp What corrective action will be accomplished for those reside found to have been affected by deficient practice: It is the policy of the facility that the facility must provide each resident food prepared by me that conserve nutritive value, and appearance. No specific residents were identified during this survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents that currently resin the facility have the potential be affected by the alleged definition practice. The Dietary Manage completed a facility wide audit 2/12/24 on all current resident determine likes and dislikes a update the Tray Card system. "Always Available Menu" will be implemented for menu options 2/17/24.	r, ents by the at thods flavor, ng ne cide al to ficient r t on ts to nd . An be	02/20/2024
		cated meat was hard, three times a week or more.			What measures will be put in place and what systemic char	nges	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/22/2024 155617 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 524 ANDERSON RD WATERS OF CHESTERFIELD SKILLED NURSING FACILITY CHESTERFIELD, IN 46017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The residents would talk about their displeasure will be made to ensure that the with the food regularly, but nothing seemed to deficient practice does not recur: change. The Administrator educated the Dietary Manager on 2/13/24 on Food temperature logs for January 2024 were food temperature logs usage, safe requested for review on 1/18/24 at 1:25 p.m. food temperatures, and food palatability. The Administrator During an interview on 1/18/24 at 1:27 p.m., the educated the dietary staff on Dietary Manager indicated the food temperature 2/13/24 on food temperature logs log had many "holes and blanks". usage, safe food temperatures, food palatability, and following During an interview on 1/18/24 at 1:30 p.m., the recipes for cook times. The Dietary Manager indicated he did not have a Administrator educated the facility method to ensure food satisfaction. He walked staff on 2/13/24 on the Always around the dining room and asked residents about Available Menu. Additionally, any their meal. employee who fails to comply with the points of the in-service may be The food temperature log for January 2024 had no further educated and/or temperatures recorded for 28 of 54 meals served. progressively disciplined as indicated. During an interview with the Administrator on 1/18/24 at 3:40 p.m., she indicated the facility did not have a method to assess and review for food satisfaction. The facility did not have a policy for food satisfaction. How the corrective action will be monitored to ensure the deficient 3.1-21(a)(2) practice will not recur. i.e what quality assurance program will be put into place: The "F804 – Food Satisfaction Audit" will be completed on 5 random residents for each meal service 5x weekly for 4 weeks, 3 random residents for each meal service 3x weekly for 4 weeks, then 3 random residents for each meal service monthly for 3 months. The "F804 - Food Temp Log Audit will be completed 5x weekly for 8 weeks, 3x weekly for

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/22/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY		524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD 'ERFIELD, IN 46017			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				4 weeks, then 1x weekly for 3 months. If the facility is within 95% compliance at the end of 6 months; then monitoring can stopped. Results of the monitor will be reviewed at the monthly QAPI meeting. Any concerns whave been addressed. However any patterns will be identified. needed Action Plan will be write by the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved.	be bring / will er, Any	
				By what date the systemic changes for each deficient will completed. February 20, 2024	be	

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