PRINTED: 03/03/2025

EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>00</u>	COMPLETED
	155233	B. WI	NG	02/10/2025
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 958 F HWY 46	

	S OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006		
(X4) ID PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	REGULTIONT ON ESC IDENTIFIED IN GRAMMITON	TAG		DATE
Bldg. 00				
Sidg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 4, 5, 6, 7, and 10, 2025. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 3 Medicaid: 43 Other: 8	F 0000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because federal and state law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiency	
	Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 14, 2025.		below is not an admission that the alleged facts occurred as presented in the statements. This report in its entirety has been reviewed by our quality Assurance Committee.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			
Bidg. 00	Based on record review and interview, the facility failed to notify the physician when a resident's blood glucose levels were out of range for 1 of 21 residents reviewed for notification of change. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed	F 0580	F580 Notify of Changes (Injury/Decline/Room, etc.) It is the policy of the facility to notify the physician when a resident's blood glucose levels are out of range. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	02/24/2025
	on 02/05/25 at 10:44 A.M. An Annual MDS		practice? The DON/Designee	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Jalena Ball Administrator 02/27/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2025		
	ROVIDER OR SUPPLIER		958 E	FADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION assessment, dated 01/16/25,	TAG	notified resident 29's physicia	DATE	
	•	nt was cognitively intact. The		blood glucose levels outside		
		included, but were not		parameters for last 6 months		
	_	anemia, coronary artery		DATE 2/11/25. How be ident		
		e, hypertension, anxiety, and		and what corrective action(s		
	depression.			taken? The DON/Designee		
				completed a 30 day look back	< of	
		nt MD orders included an		blood glucose results and not	ified	
	open-ended order, v	with a start date of 04/25/24, to		of any blood glucose results	out of	
		f Humalog insulin, three times		range on 2/11/25 What meas	ures	
	•	12:00 P.M., and 5:00 P.M. The		will be put into place and wha		
		additional open-ended order,		systemic changes will be mad		
	with a start date of 04/25/24, to check the blood			ensure that the deficient prac		
	-	ster an additional dose of		does not recur? At an in-serv	vice	
		a sliding scale (the amount of		held on 2/19/25 held by the		
		l would depend on the		DON/Designee the following was		
	_	cose level) three times a day at		reviewed with the nursing	·	
		M., and 5:00 P.M. The notified if the resident's blood		staff. Change of condition pol	-	
	glucose was greater			and procedure Notification or resident's physician of blood		
	glucose was gleater	than 331.		glucose levels outside of		
	The November and	December 2024, and January		range Any staff who fail to co	amply	
		Electronic Medication		with the points of the in-service		
	•	ord (EMAR) and Vitals		be further educated and or	Will	
		ved. The blood glucose levels		progressively disciplined as		
	-	he resident received the		indicated.		
	scheduled dose of in	nsulin were different from the		How the corrective action will	be	
	blood glucose levels	s documented when the		monitored to ensure the defic		
	sliding scale insulin	was administered, even		practice will not recur, what q		
	•	f insulin would have been		assurance program will be pu	it into	
	administered togeth	er and based off the same		place.		
	blood glucose level			The DON/Designee will moni		
				blood glucose levels 5 times		
		00 P.M., the blood glucose		week for 4 weeks, then 3 time		
		scheduled insulin was 430,		week x 4 weeks, then one time		
	-	blood glucose documented		week x 4 months for levels ou		
	was 350,	00 P.M. d. 11 . 3 . 1		range and physician notificati	on. If	
		:00 P.M., the blood glucose		the facility is within 95%		
		scheduled insulin was 377,		compliance after 6 months th		
	but the sliding scale	blood glucose documented		monitoring will be stopped. A	it the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIE		958 E I	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	was 350, On 11/26/24 at 5: documented for the but the sliding scal was 340, On 12/06/24 at 5: documented for the but the sliding scal was 350, On 12/07/24 at 5: documented for the but the sliding scal was 350, On 12/12/24 at 5: documented for the but the sliding scal was 350, On 12/12/24 at 5: documented for the but the sliding scal was 350, On 12/14/24 at 5: documented for the but the sliding scal was 350, On 12/15/24 at 12 documented for the but the sliding scal was 349, On 12/17/24 at 8: documented for the but the sliding scal was 349, On 12/23/24 at 12 documented for the but the sliding scal was 350, On 12/23/24 at 12 documented for the but the sliding scal was 373, On 12/23/24 at 5: documented for the but the sliding scal was 373, On 12/29/24 at 7: documented for the but the sliding scal was 373, On 12/29/24 at 7: documented for the but the sliding scal was 373,	200 P.M., the blood glucose escheduled insulin was 420, the blood glucose documented on P.M., the blood glucose escheduled insulin was 378, the blood glucose documented on P.M., the blood glucose escheduled insulin was 358, the blood glucose documented on P.M., the blood glucose escheduled insulin was 400, the blood glucose documented on P.M., the blood glucose escheduled insulin was 409, the blood glucose documented on P.M., the blood glucose escheduled insulin was 409, the blood glucose documented on P.M., the blood glucose escheduled insulin was 563, the blood glucose documented on P.M., the blood glucose escheduled insulin was 379, the blood glucose documented on P.M., the blood glucose escheduled insulin was 551, the blood glucose documented on P.M., the blood glucose escheduled insulin was 337, the blood glucose documented on P.M., the blood glucose escheduled insulin was 337, the blood glucose documented on P.M., the blood glucose escheduled insulin was 376, the blood glucose documented on P.M., th		monthly QAPI meeting, the monitoring of the DON /Desig will be reviewed. Any concerr will have been corrected as for Any patterns will be identified necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. By what date be completed? If of Compliance 2/24/25	nee ns und. If be /

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/10/2025		
	PROVIDER OR SUPPLIER		958 E F	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(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)	(X5) COMPLETION DATE
	was 350, On 01/04/25 at 5:0 documented for the but the sliding scale was 350, On 01/23/25 at 12 documented for the but the sliding scale was 248, and On 02/01/25 at 5:0 documented for the but the sliding scale was 350. There was no indica notified when the bigreater than 350. During an interview LPN 6 (Licensed President received sliroutine insulin and treported to the physparameters then she document in the EM the physician was no During an interview DON (Director of Mad two insulin order parameters to call the should have the sam documented and the if they were outside. The current, undated "Change in Resident provided by the DO The policy indicated."	200 P.M., the blood glucose scheduled insulin was 376, blood glucose documented 200 P.M., the blood glucose scheduled insulin was 435, blood glucose documented 200 P.M., the blood glucose scheduled insulin was 415. blood glucose documented 200 P.M., the blood glucose scheduled insulin was 415. blood glucose documented 200 P.M., the blood glucose accounted 200 P.M., the blood glucose 200 P.M., t			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER 155233			UILDING	00	COMPLETED	
		155233	B. W	ING		02/10	/2025
	PROVIDER OR SUPPLIER			958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006		
(X4) ID	SUMMARY S	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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		esentative are notified of					
	changes in the resid	ent's condition or status"					
	3.1-5(a)(3)						
F 0583	483.10(h)(1)-(3)(i)	(ii)					
SS=D		Confidentiality of Records					
Bldg. 00	,	.					
	Based on observation	on, interview, and record	F 0:	583	F-583 Personal		02/24/2025
	_	failed to maintain resident			Privacy/Confidentiality of Reco	ords	
	_	manner related to personal			It is the policy of this facility to		
	•	in a public setting for 1 of 54			maintain resident records in a		
	residents who reside	ed in the building. (Resident			private manner related to pers	onal	
	59)				information posted in a public		
	Findings in 1.4.				setting.		
	Findings include:				\M/hat carrective actions will be		
	Pasident 50's room	was observed on 02/04/25 at			What corrective actions will be		
		on the resident's door indicated			accomplished for those reside found to have been affected b		
		olation and enhanced barrier			deficient practice?	y ii ie	
		on the wall next to the door			denoient practice:		
	•	esident's name and room			Resident #59 had the information	tion	
		ment titled, "Guidelines for			removed from his door	uon	
	addressing Candida				immediately on 2/5/25, by the		
	6				DON/Designee.		
	The resident's room	was observed on 02/05/25 at					
	9:20 A.M., The sign	nage remained, including the			How will the facility identify ot	her	
	"Guidelines for add	ressing Candida auris"			residents having the potential		
	documents posted o	n the wall above the			be affected by the same defici		
	resident's name and	room number.			practice?		
	During an interview	on 02/05/25 at 9:22 A.M.,			The DON/Designee completed	d an	
	-	Nurse 5 indicated resident			audit of all resident doors in th		
		ing resident profile information,			facility on 2/5/25 to ensure no		
	·	d diagnoses information was			other personal information wa		
		ntial, and should not be out for			posted. Any issues found were		
	public viewing.				addressed accordingly.		
		on 02/05/25 at 9:30 A.M., the			What measures will be put in		
	Director of Nursing	(DON) and the Regional			place or systemic measures to)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2025	
	ROVIDER OR SUPPLIER		958 E	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
(X4) ID PREFIX TAG	REGULATORY OR Nurse Consultant in any documentation resident's diagnosis. would be removed. The resident's clinic 02/05/25 at 10:00 A Set (MDS) assessmenthe resident was more The resident's diagnosis in the resident's diagnosis. The resident's current current open-ended 02/04/25, that indicates contact isolation for The current, undated is HIPAA?" was president's at 9:52 A.I. "PROTECTED Heard all health information of the current open in the current open in the current open.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION dicated they were unaware of posted in public related to the It should not be there and al record was reviewed onM. A Quarterly Minimum Data ent, dated 01/01/25, indicated derately cognitively impaired. oses included, but were not ypertension, and depression. Int MD orders included a order, with a start date of ated the resident was in a Candida auris infection. d facility policy, titled "What by ided by the DON on M. The policy indicated, EALTH INFORMATIONany nation on a resident or ifies an individual"	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure the deficient practice of not recur? At an in-service held by the DON/Designee on 2/19/25 with nursing staff the following was reviewed. -HIPAA compliance and displayers information - Not to post resident personal information on the doors Any staff who fail to comply we the points of the in-service will further educated and or progressively disciplined as indicated. How the corrective action will monitored to ensure the deficiency practice will not recur, what quassurance program will be purplace.	be dent uality
				The Director of Nursing or designee will complete an audentryways to resident rooms to ensure no personal health information is displayed without the resident's consent 5 days weekly for 4 week, 3 days we for 4 weeks and then 1 day we for 4 months. If the facility is weekly compliance at the end of	o ut ekly eekly vithin

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155233	A. BUILDING B. WING	00	COMPLETED 02/10/2025
	PROVIDER OR SUPPLIER		958 E F	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(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)	(X5) COMPLETION DATE
				months the monitoring can be stopped. At the monthly QAPI meeting monitoring of the DON /Design will be reviewed. Any concern will have been corrected as fo Any patterns will be identified. necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution. By what date be completed? E of Compliance 2/24/25	, the nee ns und. If be
F 0684 SS=E Bldg. 00	review, the facility appropriately prior blood glucose approphysician's orders reparameters for 4 of Quality of Care. (Ro Findings include: 1. During a medicat and interview, on 0.2 Practical Nurse (LP)	on, interview, and record failed to prime an insulin pen to administration, monitor oppriately, and follow elated to medication hold 21 residents reviewed for esidents 37, 29, 22, and 43) ion administration observation 2/06/25 at 10:54 A.M., Licensed N) 4 removed a Fiasp insulin ek Medication Cart. LPN 4	F 0684	F- 684 Quality of Care It is the policy of this facility to ensure insulin pens are primed prior to administering, to monit blood glucose appropriately ar follow physician orders related medication hold parameters. What corrective action will be accomplished for those reside found to have been affected by deficient practice. Residents 37, 29, 22 and 43 were assured to the policy of the practice.	d tor nd to d to d to d to d to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2025	
	ROVIDER OR SUPPLIER		958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE
	indicated the pen has Resident 37 because who used that type write the resident's required eight units resident's blood glue performed. The LPM insulin pen and turn of the pen to 10 unit done that so she counits. The LPN aim into a plastic cup and donned gloves and pinsulin into the residence open to the room. During an interview 4 indicated the purp was to ensure there should have held the priming the pen. The Fiasp insulin pathe Regional Nurse P.M. The record ince FIASPPenTurn unitsHold the Pen Tap the top of the Pany air bubbles rise the needle pointing button until the dose of insulin should be 2. The clinical record on 02/05/25 at 10:44 assessment, dated 0			assessed by the DON/Designe on 2/11/25 and no negative outcome related to the cited practice and the physician was notified of medications given outside of parameters on 2/11 How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. The DON/Designee completed audit of residents with parameter of diabetic medications on 2/11/25, and MD notified of armedications given outside of parameters on 2/11/25. What measures will be put interplace and what system chang will be made to ensure that the deficient practice does not recomplete the following that the nursing staff.	DATE DATE DATE DATE DATE DATE DATE
	included, but were recoronary artery dises hypertension, anxie			in-service will be further educa and/or disciplined as indicated How the corrective action will	l.

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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 <u>00</u>			COMPL	ETED
		155233	B. WING			02/10/	/2025
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				958 E H			
WATERS	OF BATESVILLE,	THE		BATES	VILLE, IN 47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	A current, open-ended physician's order, with a				monitored to ensure the deficie	-nt	
	_	44, indicated the resident was			practice will not recur, what qu		
	to receive Metoprol				assurance program will be put	•	
	_	once a day. The staff were to			place.	iiito	
		if the resident's heart rate was			piace.		
		blood pressure was less than					
	110/60.	mood pressure was less than					
	110/00.				DON/designed guidit the		
	The December 202/	4, January and February 2025			DON/designee audit the Medication Administration Rec	ard	
		e resident received the					
					5 times a week for 4 weeks, th		
		e vital signs were not			3 times a week x 4 weeks, the		
	documented for the	following dates and times:			one time a week x 4 months fo		
	10/00/04 1 1 10/04/04				medication with parameters ar	ıa	
	- 12/28/24 through 12/31/24, no vital signs were				following physician orders.		
	documented,	01/17/04					
		01/17/24, no vital signs were			The DON/Designee will monito	or 10	
	documented, and	20/10/27			random staff members	_	
		02/10/25, no vital signs were			administering insulin for primin	-	
	documented.				insulin pen prior to administeri	-	
					dose weekly x 4 weeks, then 5		
		al record lacked any vital signs			random staff weekly x 4 weeks	5,	
	for the above dates.				then 3 random staff members		
					monthly x 4 months.		
		rd for Resident 22 was reviewed					
		2 P.M. A Quarterly MDS			If the facility is within 95%		
		2/07/24, indicated the resident			compliance at the end of the 6		
		mitively impaired. The			months, then monitoring can b		
	resident's diagnoses	included, but were not			stopped. Results of the monito	ring	
		ure, anemia, hypertension,			will be reviewed at the monthly	/	
	diabetes, non-Alzhe	eimer's dementia, depression,			QAPI meeting. Any concerns v	vill	
	psychotic disorder,	and respiratory failure.			have been addressed. Howeve	er,	
					any patterns will be identified.	Any	
	The current open-er	nded physician's order, with a			Action Plan needed will be wri	tten	
	start date of 04/27/2	3, indicated the resident was			by the QAPI committee. Any		
	to receive Carvedilo	ol (a blood pressure			written Action Plan will be		
	medication) 3.125 n	ng, twice a day. The staff were			monitored by the Administrato	r	
	to hold the medicati	on when the blood pressure			weekly until resolved. By what		
	was less than 120/70	0 or the heart rate was less			date the systemic changes for]
	than 60.				each deficient will be complete		
					·		
	1		1		l .		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	r í	JILDING	nstruction 00	(X3) DATE : COMPL 02/10/	ETED
	PROVIDER OR SUPPLIER		•	958 E H	ADDRESS, CITY, STATE, ZIP COD IWY 46 VILLE, IN 47006		
(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)	ΓE	(X5) COMPLETION DATE
	The November and February 2025 EM/received the medical was less than 120/7 than 60 on the folloron 11/04/24 at 8:0 was 58 and at 8:00 for 58, and 11/11/24 at 8:0 was 56, and 11/11/24 at 8:0 pressure was 100/50, and 11/20/24 at 8:0 pressure was 116/60 and 12/14/24 at 8:0 pressure was 108/60 and 12/14/24 at 8:0 pressure was 102/60 and 12/16/24 at 8:0 pressure was 102/60 and 12/16/24 at 8:0 pressure was 105/60 and 12/17/24 at 8:0 pressure was 105/60 and 11/5/25 at 8:0 pressure was 111/60 and 11/20/25 at 8:0 pressure was 116/60 and 11/20/25 at 8:0 pressure was 108/50 and 10/20/25 at 8:0 pressure was 108/50 and 10/20/25 at 8:0 pressure was 114/50 and 10/20/25 at 1:37 assessment, dated 1 was cognitively intaincluded, but were included, but were inclu	December 2024 and January, AR indicated the resident had ation when the blood pressure 0 or the heart rate was less wing dates and times: 20 A.M., when the heart rate P.M., when the heart rate was 20 A.M., when the heart rate was 20 A.M., when the blood 3, 00 P.M., when the blood 4, 00 P.M., when the blood 5, 00 P.M., when the blood 6, 00 P.M., when the blood 7, 00 P.M., when the blood 8, 00 P.M., when the blood 9, 00 P.M., when the blood 10, 00 P.M., when the blood 11, 00 P.M., when the blood 12, 00 P.M., when the blood 13, 00 P.M., when the blood 14, 00 P.M., when the blood 15, 00 P.M., when the blood 16, 00 P.M., when the blood 17, 00 A.M., when the blood 18, 00 P.M., when the blood 19, 00 P.M., when the blood 10, 00 P.M., when the blood 10, 00 P.M., when the blood 11, 00 P.M., when the blood 12, 00 P.M., when the blood			By what date be completed? Dof Compliance 2/24/25	Date	

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	OF CORRECTION	IDENTIFICATION NUMBER 155233	 JILDING	00	COMPL 02/10/	ETED
	PROVIDER OR SUPPLIER		958 E H	DDRESS, CITY, STATE, ZIP COD WY 46 /ILLE, IN 47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION on, anxiety, and depression.	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	The current open-er start date of 11/24/2 to be administered May for hypotension medication if the sy greater than 120.	aded physician's order, with a 3, indicated the resident was Midodrine 15 mg, three times a . The staff were to hold the stolic blood pressure was				
	February 2025 EMA received the Midodi systolic blood press the following dates	AR indicated the resident had rine medication when their ure was greater than 120 on and times:				
	pressure was 133/7(- On 11/23/24 at 7:0 pressure was 124/68 blood pressure was - On 11/25/24 at 7:0 pressure was 132/80	00 A.M., when the blood B and at 5:00 P.M. when the 126/86, 10 A.M., when the blood 10 at 12:00 P.M., when the blood B, and 5:00 P.M., when the				
	pressure was 122/76 blood pressure was the blood pressure v - On 11/29/24 at 12 pressure was 123/67 blood pressure was - On 12/02/24 at 7:0 pressure was 134/92 blood pressure was	200 P.M., when the blood 7 and 5:00 P.M., when the 128/78, 10 A.M., when the blood 2 and at 12:00 P.M., when the 126/88, 100 P.M., when the blood				
	pressure was 122/88 blood pressure was	00 A.M., when the blood 3 and 12:00 P.M., when the 134/74, 00 A.M., when the blood				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		A. BU	A. BUILDING <u>00</u> COME			ETED 2025	
	PROVIDER OR SUPPLIER S OF BATESVILLE,			958 E H	DDRESS, CITY, STATE, ZIP COD WY 46 VILLE, IN 47006		
(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 BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	pressure was 142/70 blood pressure was the blood pressure was 135/80 blood pressure was - On 12/11/24 at 12 pressure was 138/80 - On 12/13/24 at 7:0 pressure was 121/90 blood pressure was 121/90 blood pressure was the blood pressure was the blood pressure was 122/80 blood pressure was 122/80 blood pressure was 122/80 blood pressure was 124/70 - On 12/22/24 at 7:0 pressure was 124/70 pressure was 124/70 pressure was 142/80 blood pressure was 142/80 blood pressure was 142/80 blood pressure was 128/70 - On 12/24/24 at 7:0 pressure was 128/70 - On 12/29/24 at 12 pressure was 123/70 - On 12/30/24 at 7:0 pressure was 142/80 blood pressure was 147/10 blood pressure was 147/10 blood pressure was 147/10 blood pressure was 147/10 blood pressure was 129/70 - On 01/08/25 at 7:0	6, at 12:00 P.M., when the 128/76, and 5:00 P.M., when was 134/88, 00 A.M., when the blood 4 and 12:00 P.M., when the 123/72, :00 P.M. when the blood 6, 00 A.M., when the blood 7, at 12:00 P.M., when the 134/86, and at 5:00 P.M., when was 124/82, 00 A.M., when the blood 4, at 12:00 P.M., when the 134/77, and at 5:00 P.M., when was 128/82, 00 P.M., when the blood 2, 00 A.M., when the blood 6, at 12:00 P.M., when the 132/74, and at 5:00 P.M., when was 132/76, 00 A.M., when the blood 8, :00 P.M., when the blood 9, at 12:00 P.M., when the blood 9, at 12:00 P.M., when the 138/72, and 5:00 P.M., when the 138/72, and 5:00 P.M., when was 122/84, 00 P.M. when the blood 8, 00 A.M., when the blood 8, 00 A.M., when the blood 9, at 12:00 P.M., when the 138/72, and 5:00 P.M., when the 130/88, and at 5:00 P.M., when the 130/88, and at 5:00 P.M., when was 138/87, 00 P.M., when the blood					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COM	e survey pleted 0/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006					
	ı			1				
(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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
1110		less than 134/88, and 5:00	1110			5.112		
	_	od pressure was 132/77,						
		00 A.M., when the blood						
		4, at 12:00 P.M., when the						
	1 ^	136/68, and 5:00 P.M., when						
	the blood pressure							
	_	00 A.M., when the blood						
	pressure was 132/8							
	1	00 A.M., when the blood						
		0, at 12:00 P.M., when the						
	1 ^	128/74, and 5:00 P.M., when						
	the blood pressure							
	_	00 A.M., when the blood						
		4, at 12:00 P.M., when the						
	1 -	138/77, and 5:00 P.M., when						
	the blood pressure							
	_	00 A.M., when the blood						
		8, at 12:00 P.M., when the						
	1 -	147/83, and 5:00 P.M., when						
	the blood pressure							
	_	::00 P.M., when the blood						
	pressure was 128/8							
	1 -	00 A.M., when the blood						
	pressure was 142/8							
	- On 01/27/25 at 7:0	00 A.M., when the blood						
	pressure was 134/82	2, at 12:00 P.M., when the						
	blood pressure was	122/77, and 5:00 P.M., when						
	the blood pressure	was 136/89,						
	- On 02/03/25 at 7:0	00 A.M., when the blood						
	pressure was 122/7	7, at 12:00 P.M., when the						
	blood pressure was	138/80 and 5:00 P.M., when						
	the blood pressure							
		00 A.M., when the blood						
		3, at 12:00 P.M., when the						
	•	132/87, and at 5:00 P.M., when						
	the blood pressure							
		00 A.M., when the blood						
	1 ~	9, at 12:00 P.M., when the						
	_	128/90, and at 5:00 P.M., when						
	the blood pressure	was 132/80, and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/10/2025				ETED	
	PROVIDER OR SUPPLIER		•	958 E H	ADDRESS, CITY, STATE, ZIP COD IWY 46 VILLE, IN 47006		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I		
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
		:00 P.M., when the blood					22
	LPN 6 indicated why parameters on media resident's vital signs medication. If the many she would not admit it on the EMAR that administered with was administered with was administered if a hold parameters, the vitals and hold the many parameters. If there EMAR, then that was administered to number, then that was administered. The current, undate "PHYSICIAN-ORD PHYSICIAN ORD Regional Nurse Cor P.M. The policy indicating the facility to follow the The current facility ADMINISTRATIO provided by the DO policy indicated, " safely and appropria	on 02/07/25 at 11:26 A.M., then a resident had hold cations, she would check the sprior to administering the nedication was to be held then nister the medication and mark the medication was not what the resident's vitals were. on 02/10/25 at 10:21 A.M., the blood pressure medication had en the nurse should check the medication based on the was a check mark on the ould mean that the medication of the resident. If there was a etermined the medication was d, facility policy titled, DERS(FOLLOWING ERS)" was provided by the insultant on 02/07/25 at 12:15 dicated, "It is the policy of the e orders of the physician" policy titled, "MEDICATION on 02/10/25 at 1:08 P.M. The insultant on 02/10/25 at 1:08 P.M. The insultant on oil residents to believe and prevent symptoms, is"					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE C A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(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)	(X5) COMPLETION DATE		
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3)	n Status Maintenance					
Blug. 00	failed to follow a ac related to daily weig reviewed for nutrition	riew and interview, the facility equired a resident's weight ghts for 1 of 4 residents on. (Resident 29)	F 0692	F-692 Nutrition/Hydration Sta Maintenance It is the policy of the facility to obtain weights in accordance physician orders.	0		
	on 02/05/25 at 10:4 Data Set (MDS) ass indicated the resider resident's diagnoses limited to, diabetes, disease, heart failure depression. A current, open-end start date of 12/28/2 to be weighed daily notified if the reside	for Resident 29 was reviewed 4 A.M. An Annual Minimum ressment, dated 01/16/25, and was cognitively intact. The included, but were not anemia, coronary artery e, hypertension, anxiety, and led physician's order, with a 14, indicated the resident was a 14. The physician was to be cent had a weight gain greater day or greater than 5 pounds		What corrective action(s) will accomplished for those reside found to have been affected by deficient practice? The DON/Designee assessed resident 29 on 2/11/25 and not the MD of missed daily weigh DATE, no negative outcome in no new orders. How be identified and what corrective action(s be taken? An audit was completed by DON/Designee on 2/18/25 fo	ents by the d otified ats on and		
	The clinical record following dates: - 12/30/24 through (10 - 01/04/25), - 01/06/25 through (10 - 01/13/25), - 01/13/25 through (10 - 01/17/25), - 01/20/25, - 01/21/25, - 01/23/25 through (10 - 02/04/25).	01/07/25, 01/11/25, 01/15/25,		residents with daily weights to ensure all weights were input Any changes or corrections waddressed and changed as indicated and physician notificany missing weights on DATE. What measures will be put in place and what systemic changed will be made to ensure that the deficient practice does not result an in-service held by the Director of Nursing on 2/19/2 nurses the following was reviewed.	tted. vere ed on E, to nges ne cur?		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2025	
	ROVIDER OR SUPPLIER		958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR During an interview Licensed Practical N	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION on 02/10/25 at 11:02 A.M., Nurse (LPN) 3 indicated the weight. The CNAs (Certified	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 1 Guidelines for Obtaining Resident's Weights 2 Entering weights into MAR/TAR and	DATE
	Nurse Aides) would let the nurse know. the weight and call	I get the resident's weight and The nurse would document the physician if the resident ertain amount in a day.		following physician orders. Any staff who fail to comply w the points of the in-service will further educated and or	
	FOR OBTAINING 07/24/23, was provided: 1:08 P.M. The policy	policy titled, "GUIDELINES RESIDENTS' WEIGHTS", dated ded by the DON on 02/10/25 at cy indicated, "Accuracy with at is essential for residents in		progressively disciplined as indicated. How the corrective action will monitored to ensure the defici	
	the long-term-care sused to calculate en Further, weight is at health status and chindicate other medicineasurements can r	setting. Weight measurement is ergy, protein, and fluid needs. In indicator of nutritional and anges in weight can often cal changes. Inaccurate weight result in an increased number		practice will not recur, what quassurance program will be puplace.	uality t into
	can affect the plans residentsWeigh re day as possible, on much as possible-ea	ght changes in the facility-and of care for the esidents at the same time of the the same weight clothing as each time they are weighed"		Director of Nursing/Designee monitor residents with daily weights for weight being obtai and physician notification 5 tir a week x 4 weeks, then 3 time week x 4 weeks, then one tim	ned nes es a e a
	3.1-46(a)(1)			month x 4 months. If the facility within 95% compliance at the of 6 months, then monitoring to be stopped. At the monthly QAPI meeting	end can
				monitoring of the DON/Design be reviewed. Any concerns with have been corrected as found patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	nee II . Any be

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/10/2025			COMPLETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
					By what date be completed? By what date be completed? If of Compliance 2/24/25	Date
F 0694 SS=D Bldg. 00	failed to provide Pa maintenance for 2 or vascular access sites. Findings include: 1. The clinical record on 02/05/25 at 2:36 Data Set (MDS) assindicated the resident resident's diagnoses limited to, acute ost bone or bone marro. During an interview Director of Nursing was admitted to the had an infected heel. The resident had be wound infection sin facility.	riew and interview, the facility renteral/IV (Intravenous) site of 3 residents reviewed for state of the facility of the facility and 38) and for Resident 4 was reviewed P.M. An Admission Minimum essment, dated 01/20/25, and the facility of the right and foot. To on 02/10/25 at 8:38 A.M., the (DON) indicated the resident facility from the hospital and all wound with osteomyelitis. The included with osteomyelitis. The included wound with osteomyelitis wound with osteomyelitis.	F 06	94	F-694 Parenteral/IV fluids It is the practice of the facility in provide sight maintenance for residents with intravenous accisites. What corrective action will be accomplished for those reside found to have been affected by deficient practice. Resident 4 no longer resides in the facility. Resident 38's PIC IV line was discontinued on 1/10/2025. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken.	ents by the coccurrence coccur
	Licensed Practical I the resident had a M	on 02/10/25 at 2:25 P.M., Nurse (LPN) LPN 2 indicated Idline vascular access site in me from the hospital with an			On 2/11/25 DON/Designee completed an audit on all residents who have IV access	s to

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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 02/10/2025 155233 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 958 E HWY 46 WATERS OF BATESVILLE. THE BATESVILLE, IN 47006 (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 access site but then had to have it replaced ensure medication orders and because it would not flush. Residents with a flush orders are in correctly and Peripherally Inserted Central Catheter (PICC) line completed as ordered. or a Midline Catheter should have physician's orders to flush the line regularly. What measures will be put into place and what system changes The "PICC/MIDLINE INSERTION will be made to ensure that the DOCUMENTATION" record, dated 01/24/25, was deficient practice does not recur. provided by the Regional Nurse Consultant on 02/10/25 at 3:18 P.M. The record indicated a dual On 2/19/25 an in-service was lumen PICC line had been removed, and a Midline completed by the DON for all had been inserted. The Midline was cleared for licensed staff to include: use. 1. Documentation of assessment The clinical record indicated the resident did not of the PICC line, including receive IV medications on January 19, or 20, 2025, assessment of the insertion site, due to a lack of supplies. The resident did not and monitoring for bleeding or receive IV medications on January 22, 23, or 24, signs of infection at a minimum 2025, due to the resident's venous access site not upon insertion, admission and flushing. The clinical record lacked documentation during dressing changes for the the resident's venous access sites had been duration of the IV access flushed on a regular basis or flushed before and placement. 2. Maintenance flush after medication administration. orders. And following physician orders for scheduling residents to The Electronic Medication Administration have an IV line inserted at an Record/Treatment Administration Record outside vendor. (EMAR/ETAR) for January and February 2025, was provided by the DON on 02/10/25 at 9:19 Any staff who fail to comply with A.M. The record lacked a physician's order to the points of the in-service will be flush the resident's vascular access sites to further educated and/or maintain patency (open and unblocked) and there progressively disciplined. was no order to flush the sites before or following the IV medication administration. How the corrective action will be 2a. The clinical record for Resident 38 was monitored to ensure the deficient reviewed on 02/06/25 at 10:05 A.M. A Quarterly practice will not recur, what quality MDS assessment, dated 12/17/24, indicated the assurance program will be put into resident was cognitively intact. The resident's place. diagnoses included, but were not limited to, amputation, anemia, hypertension, PVD, diabetes, anxiety, depression, infection of amputation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155233	B. WING 02/10/2025				
					_		
NAME OF I	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP COD		
				958 E F			
WATERS	S OF BATESVILLE	, THE		BATESVILLE, IN 47006			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					DON/Designee will audit resid	ents	
	A Progress Noted,	dated 12/07/24 at 9:24 P.M.,			with intravenous lines for flush	1	
	indicated the resid	ent admitted to the facility for a			orders and physician orders for	or	
		on and had a PICC line in her			flushing and maintaining IV lin		
	right upper arm.				times a week x 4 weeks, then		
					times a week x 4 weeks, then		
	A physician's orde	r, dated 12/08/24 through			time a month x 4 months. If th		
		d the resident was to receive			facility is within 95% complian		
		ntibiotic) 1 gram, once a day for			at the end of the 6 months, the		
	a right stump infec				monitoring will be stopped.		
	A physician's orde	r, dated 12/08/24 through			Results of the monitoring will I	ре	
	01/10/25, indicated the resident was to receive				presented to the QAPI commi	ttee	
	Cefepime (an antil	piotic) 2 grams intravenously,			weekly, then monthly when		
	twice a day for a ri	ight stump infection.			appropriate. Any patterns will	be	
					identified. If needed, an Action		
	A physician's orde	r, dated 12/08/24 at 10:20 A.M.,			Plan will be written by the QAI	기	
	indicated the staff	were to flush the IV-midline			committee. Any written Action		
	with 10 mls norma	al saline before and after			Plan will be monitored weekly		
	infusions. The ord	er had no scheduling details or			the Administrator until resolve	-	
	assigned times to b				Orders for a PICC/IV will be		
		•			reviewed daily M-F at the CQI		
	The clinical record	l indicated the resident did not			(Clinical Quality Indicator)		
		nycin on the following dates:			meeting, to ensure orders are		
		, ,			correct and being implemente		
	- 12/08/24 due to t	he medication being			policy and procedure.	- p	
	unavailable,	8			Fema, and procedure.		
	· · · · · · · · · · · · · · · · · · ·	he resident needing a new PICC			By what date be completed?	Date	
	line placed, and	e			of Compliance 2/24/25		
	*	vaiting on the PICC line					
	verification.	5					
	The clinical record	l indicated the resident did not					
		me medication on the following					
	dates and times:	2					
	- 12/08/24 at 8:00	P.M., due to the medication					
	being unavailable,						
		A.M., and 8:00 P.M., due to new					
	PICC needing place						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIE		958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION
	- 12/10/24 at 8:00 line verification.	A.M., due to waiting on PICC			
		And Consultation Reports ent had a PICC/midline placed ates:			
	- 12/09/24 at 11:25 - 12/14/24 at 4:10 - 12/14/24 at 8:00 - 01/04/25 at 3:50	P.M., P.M., and			
	The resident's PICC/midline was discontinued on 01/10/25.				
		lacked documentation that the dline was flushed from 12/07/24			
	12/20/2024 at 5:05 recommended a reresident to get a ce that is longer than	Disease Progress Note, dated P.M., indicated it was ferral was to be sent for the ntral line (an intravenous line a regular IV and goes all the ear the heart or just inside the			
	indicated the staff hospital about gett	r, with a start date of 12/24/24, were to contact the local ing a central line placed due to line placement, for 5 days.			
	end date 12/30/24,	r, with start date 12/26/24 and indicated the staff were to atment with the general al line for 4 days.			
		4 EMAR and clinical record wing related to the central line:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIER S OF BATESVILLE, THE	958 E ⊦	ADDRESS, CITY, STATE, ZIP COD IWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	- 12/24/24, the EMAR indicated to see nurse note. There was no nurse note related to the appointment, - 12/25/24 and 12/26/24, EMAR was left blank, - 12/27/24 the EMAR indicated to see a nurse note. The nurse note indicated the physician's office was closed that day, and - 12/28/24 through 12/30/24, the EMAR was left blank. The clinical record lacked any other documentation related to the central line. During an interview on 02/07/25 at 1:30 P.M., LPN 2 indicated if a resident was admitted to the facility with a PICC/Midline the medications would be delivered by pharmacy. They ran three times a day, and the nurse would need to input orders for it to be flushed. There was no reason anyone would have a PICC/Midline without flush orders. To schedule appointments, she would put it on the EMAR, and the nurse would have to check it off like a medication when it was done. If it didn't get done, then the DON would need to follow-up to make sure it was completed. During an interview on 02/10/25 at 10:03 A.M., the DON and the Regional Nurse Consultant indicated when a resident admitted to a facility with a PICC/Midline the nurse would input order for the resident to get flushes to the line. Resident 38 had an order for flushes, but the nurse didn't put in any scheduling details, so it didn't show up on the EMAR to be completed. If the physician gave orders for the pharmacy to dose a resident's medications, then the facility would follow the orders from the pharmacy. The nurse that took the order to increase the Vancomycin to 1.25 grams should have changed the order in the clinical record. Since the infectious disease NP made a			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/10/2025				
	ROVIDER OR SUPPLIER OF BATESVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	recommendation for a central line the facility should have followed up with the physician to get the line placed.					
	The current facility policy titled, "Flushing a Peripheral Intravenous Catheter", dated January 2016, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "Specific flush orders must be documentedFlushing is performed to ensure and maintain catheter patency, and to prevent the mixing of incompatible medications/solutionsA physician order is required for flushing of a peripheral IV catheter. The order must include:Flushing agentVolumeFrequency"					
	The current facility policy titled, "Flushing a Midline Catheter", dated January 2016, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "Specific flush orders must be documentedFlushing is performed to ensure and maintain catheter patency, and to prevent the mixing of incompatible medications/solutionsA physician order is required for flushing of a peripheral IV catheter. The order must include:Flushing agentStrength/concentrationVolumeFrequen cy"					
	The current, undated, facility policy titled, "PHYSICIAN-ORDERS(FOLLOWING PHYSICIAN ORDERS)" was provided by the Regional Nurse Consultant on 02/07/25 at 12:15 P.M. The policy indicated, "It is the policy of the facility to follow the orders of the physician"					
F 0698 SS=D	3.1-47(a)(2) 483.25(I) Dialysis					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155233	B. W	ING		02/10/2	2025
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
Bldg. 00	Based on interview failed to completed following a resident residents reviewed following an interview Resident 24 indicated dialysis treatments of Friday. During an interview Meeting, on 02/06/2 indicated sometimes dialysis, she had to coat on for a half and The clinical record on 02/06/25 at 2:41 Data Set assessment resident was cognitic diagnoses included, failure, hypertension diabetes. The resident treatments. During an interview Director of Nursing staff were supposed on the "DIALYSIS/COMMUNICATIO dialysis binder each dialysis facility for the "DIALYSIS/OI COMMUNICATIO COMMUNI	and record review, the facility assessments before and seed dialysis treatments for 1 of 2 for dialysis. (Resident 24) of on 02/04/25 at 11:25 A.M., and she left the facility for on Monday, Wednesday, and while at the Resident Council 25 at 2:15 P.M., the resident seed when she got back from sit in her wheelchair with her a hour before staff helped her. for Resident 24 was reviewed P.M. A Quarterly Minimum to the dialogue of the fively intact. The resident's but were not limited to, heart in, renal insufficiency, and the following interest dialysis of on 02/06/25 at 3:20 P.M., the (DON) indicated the facility to complete an assessment to COBSERVATION on FORM" in the resident's time the resident went to the treatment.	F 00		F-698 Dialysis It is the policy of the facility to complete an assessment before and after a resident's dialysis treatment. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? The DON/Designee assessed Resident 24 has had no negate outcomes from the cited practice. How be identified and what corrective action(s be taken? An audit was completed by the DON/Designee for all resident dialysis for assessment before and following dialysis treatment any concerns were immediate addressed and physician notified on 2/11/25 What measures will be put into place and what systemic chain will be made to ensure that the deficient practice does not reconcern to the deficient practice held by the Director of Nursing on 2/19/25 nurses the following was reviewed: Dialysis communication form to	ore one onts y the tive tive one ont, ely one one ont, ely one one one ont one	DATE 02/24/2025
		resident refuse to go to			completed before and followin		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155233	B. W	ING		02/10/	2025	
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)	
PREFIX		H DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	dialysis sometimes	but had been to dialysis a few			dialysis treatment.			
	•	d February. The dialysis binder						
		ords for 12/13/24, 12/20/24, and			Any staff who fail to comply wi			
	12/31/24. The dialysis provider had completed their portion of the forms. The facility failed to complete their portion of the forms which included signed assessments before and after dialysis				•	the points of the in-service will be		
					further educated and or			
					progressively disciplined as indicated.			
	treatments.	before and after diarysis			maidated.			
					How the corrective action will I	ре		
	The current "Dialysis Guideline" policy, with a reviewed date of 04/04/16, was provided during				monitored to ensure the deficie	ent		
					practice will not recur, what qu	-		
	the Entrance Conference. The policy indicated,				assurance program will be put	into		
	_	nen a resident's disease			place.			
		nemodialysis may exceed the provided to residents in						
		ngCommunication between						
	-	r and center staff should			Director of Nursing/Designee v	will		
		mmunication including review			monitor dialysis communicatio			
		anges in condition or mood,			forms 5 times a week x 4 weel			
	response to the treat	tment, and evaluation of the			then 3 times a week x 4 weeks	5,		
	vascular access site	"			then one time a week x 4			
					months. If the facility is within			
	3.1-37(a)				95% compliance at the end of			
					months, then monitoring can b	е		
					stopped.			
					At the monthly QAPI meeting,	the		
					monitoring of the DON/Design			
					be reviewed. Any concerns will			
					have been corrected as found	. Any		
					patterns will be identified. If			
					necessary, an Action Plan will	be		
					written by the committee. Any			
					written Action Plan will be	_		
					monitored by the Administrato weekly until resolution. By what			
					date be completed?	41.		
					22.13 50 00111p.0004.			

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· - 1		155233	B. WING		02/10/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0727 SS=E	483.35(b)(1)-(3)	Wk, Full Time DON		By what date be completed? Dat of Compliance 2/24/25		
Bldg. 00	Based on interview failed to provide the duty for eight hours reviewed. Findings include: The "as worked" nu had not been an RN hours on the follow - Saturday 07/13/24 - Sunday 07/14/24, - Saturday 08/10/24 - Sunday 08/10/24 - Sunday 08/10/24 - Sunday 08/10/24 - Sunday 08/25/24, - Saturday 09/07/24 - Sunday 09/08/25 - Sunday 09/22/24, - Saturday 09/22/24, - Saturday 09/22/24, - Saturday 12/14/24 - Sunday 12/15/24, - Saturday 02/08/25 - Sunday 02/09/25.	and record review, the facility e required RN coverage on a day for 16 of the 21 days arsing schedule indicated there from duty for eight consecutive ing dates:	F 0727	F-727 RN 8 hours/7 days/, Full Time DON It is the policy of the facility to ensure RN coverage on duty for eight hours day. What corrective action(s) will be accomplished for those residents found to have been affected by t deficient practice? No resident has been negatively impacted by this finding. 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 reside in the facility have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic change	he	

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The Director of Nursing (DON) indicated they did

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will be made to ensure that the

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

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIER		958 E	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE	
	The current, undate: "Registered Nurse (the DON on 02/10/2 indicated, "It is th provide the services	ffing in the previous months. d facility policy, titled Coverage" was provided by 25 at 9:19 A.M. The policy e policy of the facility to of an RN for at least 8 er 24 hour day, 7days		At an in-service held by the Administrator/Designee on 2/19/25for the DON, ADON a Staffing Coordinator the follow was reviewed: 1. Federal regulation related staffing requirements 2. Scheduling strategy to ens 8hrs of consecutive RN cover is present daily. Any staff who fail to comply with the points of the in-service wifurther educated and or progressively disciplined as indicated. How the corrective action will monitored to ensure the deficipractice will not recur, what quassurance program will be puplace. DON/Designee will audit staff for RN 8 consecutive hours 5 times a week x 4 weeks, then time a week x 4 weeks, then time a week x 4 weeks, then time a week x 4 wonths. If the facility is within 95% compliant at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meeting monitoring of the DON/Designee reviewed. Any concerns we have been corrected as found.	nd ving to RN ure rage with II be be ient uality it into ing a 3 a one ee ince ince in the inee ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155233	B. WI	NG		02/10/2	2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID MONITORING IN AN OF CONDUCTION		Ī	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.12	DATE
					patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution. By what date be completed? If of Compliance 2/24/25	r	
F 0755 SS=D Bldg. 00	Based on record rev failed to provide IV timely manner for 2 antibiotics. (Resider Findings include: 1. The clinical record on 02/05/25 at 2:36 Data Set (MDS) assindicated the resident resident's diagnoses limited to, acute ost bone or bone marro. The resident was ad 01/13/25. During an interview Director of Nursing was admitted to the had an infected heel From admission he facility had run out tubing for two days.	/Pharmacist/Records riew and interview, the facility (Intravenous) antibiotics in a of 3 residents reviewed for IV	F 07	755	F-755 Pharmacy /Procedures/ Pharmacist/ Records It is the policy of this facility to provide IV medications in a tin manner. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? Residents 4 no longer resides the facility resident 29's was assessed by the DON on 2/11 no negative outcome related to cited practice. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. DON/Designee completed an	nely pe ints y the in /25 o the	02/24/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155233	B. W	WING		02/10/2025	
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L.		958 E F			
WATERS	OF BATESVILLE,	THE	BATESVILLE, IN 47006				
(X4) ID	Г			ID		I	(Y5)
PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORREC			(X5) COMPLETION
TAG	·	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
TAG		The pharmacy did not send		IAG	intravenous antibiotics for		DAIL
		nedications. The facility had			availability of medications on		
	ordered some IV tubing from a supplier who no				2/11/25, any concerns were		
	longer carried tubing. As soon as they discovered				immediately addressed.		
	_	longer carried tubing, they			miniodiatory dual occou.		
		cy, and they delivered a box.			What measures will be put in		
	The pharmacy delivered once early in the				place and what systemic char	nges	
		:00 A.M., and 7:00 A.M., and			will be made to ensure that the	-	
	again, later in the afternoon, usually around 5:00				deficient practice does not rec		
	P.M., or 6:00 P.M. If staff ordered something by				·		
	3:00 P.M., they would usually have it by 7:00 A.M.						
	the next day. They had two local pharmacies they						
	could get supplies from in an emergency.				An in-service held on 2/19/25	held	
					by DON/Designee the following	ng	
		lication Administration			was reviewed the nursing staf	f.	
		Administration Record					
		January 2025, was provided by			Medication Administration and	t	
		25 at 9:19 A.M. The record			Ordering Medications		
		nt was to receive the following					
	· ·	for the acute infection in his			Following physician orders.		
	foot:						
					How the corrective action will		
		nilligrams (mg) one time a day,			monitored to ensure the defici		
		start date of 01/15/25, and an			practice will not recur, what qu	-	
	end date of 02/20/2	5, and			assurance program will be put	t into	
	G-f: 2	4 4 J4 9:00 A M			place.		
		t, two times a day, at 8:00 A.M., a start date of 01/16/25, and an					
	and 8:00 P.M., with end date of 02/21/2:						
	end date of 02/21/2.	J.			DON/designee will audit resid	ente	
	The record indicate	d the resident did not receive			receiving IV antibiotics for time		
		e following dates and times			administration 5 times a week	•	
	due to supplies not	9			weeks, then 3 times a week x		
	ase to supplies not	aranate.			weeks, then one time a week		
	- Daptomycin on 01	/19/25, 01/20/25, at 2:00 P.M.,			months. If the facility is within		
	and	, -, -,,			95% compliance at the end of	the	
					6 months; then monitoring car		
	- Cefepime on 01/1	9/25 at 8:00 A.M. and 8:00 P.M.,			stopped		
	and 01/20/25 at 8:0				''		
	2. The clinical recor	rd for Resident 29 was reviewed			Results of the monitoring will I	be	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233		JILDING	onstruction 00	(X3) DATE (COMPL 02/10/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(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 BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	on 02/05/25 at 10:4 assessment, dated 0 was cognitively intaincluded, but were a coronary artery dischypertension, anxied A Progress Note, daindicated the reside (Urinary Tract Inferobtained to place a antibiotic). A vascut to the facility and p A physician's order 11/26/24, indicated Merrem, 1 gram ev The November 202 did not receive the adates and times: - 11/19/24 from 8:0 - 11/20/24 from 6:0 to 6:00 P.M., and 8 - 11/21/24 from 6:0 to 6:00 P.M. (there - 11/23/24 from 4:0 blank in the EMAR A Progress Note, daindicated the Merre administered due to deliver. A Progress Note, daindicated the Merre administered due to deliver.	4 A.M. An Annual MDS 1/16/25, indicated the resident act. The resident's diagnoses not limited to, diabetes, anemia, ease, heart failure, tty, and depression. ated 11/19/24 at 9:40 A.M., nt was positive for a UTI ction). A new order was PICC line for IV Merrem (an allar access nurse was to come lace the PICC line. dated 11/19/24 through the resident was to receive ery 8 hours for a UTI for 7 days. 4 EMAR indicated the resident antibiotics on the following 40 P.M. to 10:00 P.M., 60 A.M. to 10:00 P.M., 60 A.M. to 10:00 P.M., 60 A.M. to 10:00 A.M., 4:00 P.M. was a blank in the EMAR), and 60 P.M. to 6:00 P.M. (there was a constant of the pharmacy to ated 11/19/24 at 11:08 P.M., constant of the medication was not to the medication was not to the medication being narmacy stated the medication		TAG	reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, an patterns will be identified. Any be written by the QAPI commit Any written Action Plan will be monitored by the Administrato weekly until resolved. By what date be completed? Expression of Compliance 2/24/25	ve y will ttee.	DATE
	outa de mere mai						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>			COMPLETED	
		155233	B. W	ING	<u> </u>	02/10/2025		
				CTDEET A	DDDESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	8		958 E H	ADDRESS, CITY, STATE, ZIP COD			
\\\\\\		TUE						
WATERS	OF BATESVILLE,	INE		DATES	VILLE, IN 47006			
(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 OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	A Progress Note, da	ated 11/20/24 at 5:26 P.M.,						
	indicated the Merre	m medication was not						
	administered due to	the medication being						
	unavailable. The ph	armacy stated the medication						
	would be there that	night.						
		ated 11/20/24 at 11:41 P.M.,						
		m medication was not						
	_	harmacy was called and						
	clarified that the me	edication had not been						
	delivered to the faci	ility.						
		ated 11/21/24 at 2:33 P.M.,						
		m medication was not						
		the medication being absent						
	from the facility.							
	~	on 02/07/25 at 1:30 P.M., LPN						
		resident started on IV						
	-	rmacy would send the						
	-	narmacy delivered medications						
	three times a day.							
	_	on 02/10/25 at 2:37 P.M., the						
		ensure residents received all						
		EMAR would be monitored to						
		s signing off the medication.						
		ed IV antibiotics, they should						
	be delivered the nex	ct day to start the medication.						
		00/10/05 + 0.11 53.5 - 1						
	-	on 02/10/25 at 3:11 P.M., the						
	· ·	pharmacy had cut off times for						
	_	ns. If the staff ordered						
		6:00 A.M., they would get						
	there by 6:00 P.M. a	and vice versa.						
		10.7.11.20						
		rd for Resident 38 was reviewed						
		5 A.M. A Quarterly MDS						
	assessment, dated 1	2/17/24, indicated the resident						

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155233)	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 02/10	LETED
	PROVIDER OR SUPPLIER S OF BATESVILLE, THE	958 E F	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	was cognitively intact. The resident's diagnoses included, but were not limited to, amputation, anemia, hypertension, PVD, diabetes, anxiety, depression, infection of amputation.				
	A Progress Note, dated 12/16/24 at 10:01 A.M., indicated the pharmacy was informed of the resident's trough level for the Vancomycin. The pharmacy was increasing the dose from 1 gram to 1.25 grams. The medication was not available in the emergency drug kit and would be started when it arrived from the pharmacy.				
	The residents December 2024 EMAR indicated the resident had received Vancomycin 1 gram on 12/17/24 and 12/18/24 and was on hold from 12/19/24 through 12/21/24.				
	The clinical record lacked an order for the medication to be increased to 1.25 grams.				
	The current facility policy titled, "PHARMACY HOURS AND DELIVERY SCHEDULE", dated February 2017, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "is open 24 hours/365 days a year. New orders and refill requests may be faxed or sent electronically at any time"				
	The current, undated, facility policy titled, "PHYSICIAN-ORDERS(FOLLOWING PHYSICIAN ORDERS)" was provided by the Regional Nurse Consultant on 02/07/25 at 12:15 P.M. The policy indicated, "It is the policy of the facility to follow the orders of the physician"				
	3.1-25(a)				
F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155233	B. WI	NG	<u> </u>	02/10/2025	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			958 E H			
\MATERS	OF BATESVILLE,	THE			VILLE, IN 47006		
WATERC	OF BATEOVILLE,	111L		DATEO	VILLE, IIV 47 000		
(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 APPROPRI		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00							
	Based on observation, interview, and record review, the facility failed to store medications		F 07	61	F-761 Label/Store Drugs and		02/24/2025
					Biologicals		
		of 3 medication carts reviewed			It is the intent of this facility to		
		on rooms reviewed. (39 Back			ensure that medication stored		
		ont Medication Cart, Rehab			properly.		
		d the 39 Hall Medication					
	Room)				What corrective action will be		
					accomplished for those reside		
	Findings include:				found to have been affected by	y the	
					deficient practice.		
	During a medication administration observation						
	on 02/06/25 at 10:54 A.M., Licensed Practical				The DON/Designee disposed		
		oved a Fiasp insulin pen from			the loose pills in the Med Cart	on	
		tion Cart. The pen was laying			Rehab Medication Cart and		
	-	er of the medication cart and			disposed of insulin with no nar	ne	
		The pen was labeled with an			on 2/11/25		
	-	". The pen was not labeled					
		ne or anything that would			The DON/Designee disposed	of	
		n belonged to. LPN 4 indicated			the outdated and undated		
		ened and was for Resident 37			Tuberculin on 39 Hall Medicati	ion	
	-	he only resident who used			room on 2/11/25		
		The LPN proceeded to write					
		on the pen and administer the			The DON/Designee placed		
	insulin to Resident 3	37.			resident 37's insulin in a bag v	vith	
					the resident's name, dispose o		
		ation Cart was observed on			loose pill and clean cart of loos	se	
		M., with LPN 3 and contained			paper bites and spilled substa	nce	
	the following loose	pills:			on 2/11/25		
	- one small oval pea	ch tablet,			How other residents having the	e	
	- one medium round				potential to be affected by the		
	- one medium round	- ·			same deficient practice will be		
	- one small oval wh	ite tablet,			identified and what corrective		
	- one small oval blu	e tablet,			action will be taken.		
	- one small oval red	tablet,					
	- one small round pi	ink tablet,			The DON/Designee completed	t	
	- one small round w				medication carts and medication		
	- one medium round				room audits for undated and		
	- one large oval whi				unlabeled tuberculin serum		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC			ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155233	B. W	NG		02/10/2025	
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
				958 E F			
WATERS	OF BATESVILLE,	THE		BATES	VILLE, IN 47006		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	- one medium orang	ze capsule.			insulins, disposed of loose pills	s on	
	`	5 I			2/11/25		
	The medication cart had a section of a drawer				_,,		
	covered in a spilled substance and several bits of				What measures will be put in		
	_	d heavily throughout the cart.			place and what systemic chan	aes	
	r-r				will be made to ensure that the	-	
	LPN 3 indicated the	e pharmacy occasionally came			deficient practice does not rec		
		medication carts. In-house			denoient practice does not rec	ui.	
		e carts clean. The LPN was			An in-service held 2/19/25 by	the	
		g the medications with a			DON/designee the following w		
	second nurse.	s the medications with a			reviewed:	as	
	second nurse.				reviewed.		
	3. The Rehab Medication Cart was observed on				 Medication storage, dating vial	lc	
	02/10/25 at 9:53 A.M., with LPN 2 and contained				when opened date, storing ins		
	the following loose				-	uliii	
	the following loose	pms.			pulled from the in a bag with	_ f	
		1.14. 4.1.1.4			resident's names, cleanliness		
	- one small round w				medication carts and disposing of		
	- one small round p				loose pills in medication cart.		
	- one large round ha	all of a white tablet.					
	I DO 10 1 1 1 1 1 1				Additionally, any staff that fails	to	
		insulin pens should have a			comply with the points of this		
		them. Per their facility policy,			in-service will be further		
		e insulin pen away and she			educated/disciplined as indica	ted.	
	proceeded to do so.						
					How the corrective action will be		
		ication Room was observed on			monitored to ensure the deficie		
		A.M. with LPN 3. The medication			practice will not recur, what qu	-	
	_	ed two opened vials of			assurance program will be put	into	
	` ′	rum, one with an opened dated			place.		
		s half full and one that was					
	undated that was ha	alf full. LPN 3 indicated the TB			The DON/Designee will audit		
	serum should be da	ted when opened. It should be			medication carts and medication	on	
		lays. The one dated 11/07/24			rooms for loose pills in cart,		
	should have been di	isposed of. LPN 3 disposed of			insulin dated and store in bag,	and	
	the outdated serum	vial immediately. There were			undated Tuberculin five times	а	
	no delivery dates or	n the serum bottles.			week x 4 weeks, then 3 times	а	
					week x 4 weeks, then one time		
	During an interview	and observation on 02/10/25			week 4 months. If the facility is		
	at 10:41 A.M., the I	Director of Nursing (DON)			within 95% compliance at the		
		on the floor administered the			of the 6 months; then monitoring		
	I		1		1	9	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2025
	PROVIDER OR SUPPLIE S OF BATESVILLE		958 E I	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	TB tests to the new had several new ad This refrigerator w they kept the TB set DON on 02/10/25 indicated, "A via which has been ent should be discarded date" The current "MED FACILITY" policy	wadmission residents. They dmissions in the last 30 days. The state only refrigerator where derum. kage insert was provided by the at 10:49 A.M. The record of TUBERSOL (TB serum) tered and in use for 30 days dDo not use after expiration of ICATION STORAGE IN THE total days and the state of the state		can be stopped Results of the monitoring will reviewed at the monthly QAF meeting. Any concerns will he been addressed. However, a patterns will be identified. An Action Plan needed will be w by the QAPI committee. Any written Action Plan will be monitored by the Administrat weekly until resolved. By what date the systemic changes for each deficient will be completed.	be PI ave ny y ritten or at
5.0770	policy indicated, " are stored safely, so the manufacture or 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(o)	ON on 02/10/25 at 1:08 P.M. TheMedications and biologicals ecurely, and properly following supplier recommendations"		By what date be completed? of Compliance 2/24/25	Date
F 0770 SS=D Bldg. 00	Findings include: Resident 27's clinic 02/06/25 at 11:00 A Set assessment, day	v and record review, the facility and tests for 1 of 5 residents atory services. (Resident 27) cal record was reviewed on A.M. A Quarterly Minimum Data ted 01/13/25, indicated the rately cognitively impaired. The	F 0770	F-770 Laboratory Services It is the policy of this facility to obtain blood tests for residen What corrective action(s) will accomplished for those resid found to have been affected deficient practice? The DON/Designee notified	be ents

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155233	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR resident's diagnoses limited to, diabetes, The resident's curre were not limited to, start date of 06/07/2 (a blood test that me glucose level over the month(s). Based on the physic tests should have be September, and Dec A1C lab (laboratory provided by the Dir resident's A1C was December of 2024. During an interview DON indicated the provided were all the resident's record. The resident's required I The current, undates SCHEDULING/TR DON on 02/10/25 a indicated, "It is the ensure that laborato physician are system	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION included, but were not anxiety, and hypertension. Int MD orders included, but an open-ended order, with a 3, to check the resident's A1C casures the average blood the past 2 to 3 months) every 3 Inian's orders, the A1C blood the obtained in March, June, tember of 2024. The resident's The results for 2024 were tector of Nursing (DON). The techecked in March and If on 02/07/25 at 2:24 P.M., the tecopies of the A1C labs she that were located in the the facility missed some of the the facility policy, titled "LAB ACKING", was provided by the the test of the facility to the policy scheduled and the policy is obtained and results		ESVILLE, IN 47006 PROVIDER'S PLAN OF CORRECTION	be e e e e e e e e e e e e e e e e e e		
				DON/Designee will implemer audit tool to monitor compliar	l l		

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

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIE		958 E	ADDRESS, CITY, STATE, ZIP COD HWY 46 SVILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				with laboratory orders to ensure orders are completed. This are will be completed 5x a week x weeks, then 3 x a week x 4 weeks, then one time a week weeks, then once a month x 3 months. ¿If the facility is within 95% compliance at the end of 6 months, then monitoring car stopped. Results of the monitoring will reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, are patterns will be identified. Any Action Plan needed will be wreby the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? If of Compliance 2/24/25	udit 4 x 4 the h be be ve ty titten
F 0812 SS=D Bldg. 00	Based on observati failed to maintain a working order rela kitchen observation	re/Prepare/Serve-Sanitary on and interview, the facility a kitchen exterior door in good ted to food safety for 3 of 3 ns. This deficient practice had eet 52 of 54 resident who a the kitchen.	F 0812	F-812 Food Procurement, Store/Prepare/Serve Sanitary It is the intent of this facility of maintain a kitchen door in goo working order.	
	Findings include:	itchen observation on 02/04/25		What corrective action(s) will accomplished for those reside found to have been affected be deficient practice?	ents

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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 <u>00</u>		00	COMPLETED				
155233		B. WING 02/10/2025			2025				
				CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER									
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\				958 E HWY 46					
WATERS	OF BATESVILLE,	IHE		BATESVILLE, IN 47006					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE		
	at 10:30 A.M., an ex	xterior kitchen door was							
	cracked open about	1/2 to 1 inch that the outside		No residents were identified					
	was visible. The Di	etary Manager closed the door.							
	The bottom of the d	oor contained a door draft			How other residents having th	e			
	stopper that was bro	oken on the right side where			potential to be affected by the				
	the door opened to	the outside. The part that was			same deficient practice will be	;			
	broken left an appro	eximately 2-inch gap at the			identified, and what corrective	;			
	bottom of the door.				action will be taken.				
	During an observati	on on 02/04/25 at 11:01 A.M.,			All residents have the potentia	al to			
	an exterior kitchen	door was cracked open about			be affected by this deficient				
	1/2 to 1 inch that th	e outside was visible. The			practice, therefore, this plan o	f			
	bottom of the door contained a door draft stopper				correction applied to all the				
	that was broken on the right side where the door				residents that reside in the				
	opens to the outside	e. The part that was broken			facility.				
	left an approximate	ly 2-inch gap at the bottom of							
	the door.				The Maintenance				
					Director/Designee repaired the	е			
	During an observati	on and interview on 02/10/25			kitchen doon on 2/10/25.				
		xterior kitchen door was							
	_	1/2 to 1 inch that the outside			What measures will be put in				
		ttom of the door contained a			place and what systemic char	-			
		hat was broken on the right			will be made to ensure that the	е			
		opens to the outside. The			deficient practice does not rec	cur?			
	_	n left an approximately 2-inch							
		f the door. She indicated the			The ADM/Designee educated				
		he door closed as it didn't shut			maintenance director on repai	iring			
		en piece in the bottom of the			doors when broken and				
		that for a couple weeks. She			preventative maintenance on				
	had verbally told th	e Maintenance Director about			2/19/25				
	it.								
					How the corrective action will				
	_	on 02/10/25 at 10:53 A.M., the			monitored to ensure the defici				
		or indicated he was notified of			practice will not recur, what qu				
	_	en in the kitchen few weeks			assurance program will be put	t into			
	~	aff were educated to make sure			place.				
	1	sed. He had no documentation							
		d to be fixed, and it would be			The Maintenance				
	fixed by the end of	the day.			Director/Designee will audit				
					exterior doors gaps five times	а			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPP		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIER		958 E H	ADDRESS, CITY, STATE, ZIP COD HWY 46 VILLE, IN 47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	INFORMATION", by the Regional Dii 02/10/25 at 3:04 P.1 "Maintenance Re will check all nurse carts during mornin Maintenance reques requests as time allo nature, it will be ad orders needed to be	policy titled, "OTHER dated 12/05/23, was provided rector of Operations on M. The policy indicated, quest LogMaintenance staff ss' stations and housekeeping agrounds to pick up the st Logs and take care of the lows. If an issue is urgent in dressed immediatelyWork of completed in a timely ectionsCheck for holes/gaps d"		week x 4 weeks, then 3 times week x 4 weeks, then once a month x 4 months. If the facilit within 95% compliance at the of the 6 months, then monitorican be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will habeen addressed. However, an patterns will be identified. Any Action Plan needed will be wriby the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved. By what date be completed? If of Compliance 2/24/25	y is end ng pe ve y tten
F 0842 SS=D Bldg. 00	Based on record rev failed to notify the blood glucose level	70(i)(1)-(5) 5 - Identifiable Information wiew and interview, the facility physician when a resident's s were out of range for 1 of 21 for notification of change.	F 0842	F- 842 Resident Records-Identifiable Information It is the policy of this facility to notify the resident's physician out-of-range blood glucose leve	of
	on 02/05/25 at 10:4 (Minimum Data Se	for Resident 29 was reviewed 4 A.M. An Annual MDS t) assessment, dated 01/16/25, nt was cognitively intact. The		What corrective action will be accomplished for those reside found to have been affected b deficient practice. The DON/Designee notified	nts

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
1552		155233	B. WING		02/10/2025		
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8		958 E F			
\\\∆TED¢	OF BATESVILLE,	THE			VILLE, IN 47006		
WAIERS	OI DATESVILLE,	11112		PAIES	VILLE, IIN 47 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	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			ļ	TAG	DEFICIENCY)		DATE
		s included, but were not			resident 29's out of range bloc	od	
		anemia, coronary artery			sugars on 2/11/25.		
		e, hypertension, anxiety, and					
	depression.				How other residents having th		
					potential to be affected by the		
		nt MD orders included an			same deficient practice will be		
		with a start date of 04/25/24, to			identified, and what corrective		
		of Humalog insulin, three times			action will be taken.		
	I	12:00 P.M., and 5:00 P.M. The					
		additional open-ended order,			The DON/Designee completed		
		04/25/24, to check the blood			30 day look back of blood glud		
	_	ster an additional dose of			levels and notified the residen	t's	
	Humalog based on a sliding scale (the amount of				physician of any concerns.		
	insulin administered would depend on the						
	_	cose level) three times a day at			What measures will be put into		
		.M., and 5:00 P.M. The			place and what system chang		
		notified if the resident's blood			will be made to ensure that the		
	glucose level was greater than 351.				deficient practice does not rec	ur.	
	The Meyensher and	December 2024 and January			A. in comice held on 2/40/25	امام ما	
	February 2025, Ele	December 2024, and January,			An in-service held on 2/19/25		
		ord (EMAR) and Vitals			by DON/Designee the followin was reviewed:	ig	
		wed. The blood glucose levels			was reviewed.		
	_	he resident received the			Notifying the physician of		
		nsulin were different from the			out-of-range blood sugars and		
		s documented when the			following physician orders.		
	_	was administered, even			Tonowing priyalolari ordera.		
	_	of insulin would have been			How the corrective action will	he	
	1	er and based off the same			monitored to ensure the defici-		
	blood glucose level				practice will not recur, what qu		
	22000 5130000 10 101	-			assurance program will be put	-	
	- On 11/09/24 at 5:00 P.M., the blood glucose				place.		
		scheduled insulin was 430,					
		e blood glucose documented					
	was 350,						
	·	:00 P.M., the blood glucose			DON/designee will monitor blo	ood	
		scheduled insulin was 377,			glucose levels 5 times a week		
		e blood glucose documented			weeks, then 3 times a week x		
	was 350,	. 6			weeks, then one time a week		
	•	00 P.M., the blood glucose			months. If the facility is within		
- On 11/20/24 at 3.00 1.1vi., the blood glucose				1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		 UILDING	instruction 00	(X3) DATE S COMPLI 02/10/2	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE		STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
	documented for the but the sliding scale was 340, - On 12/06/24 at 5:0 documented for the but the sliding scale was 350, - On 12/07/24 at 5:0 documented for the but the sliding scale was 350, - On 12/12/24 at 5:0 documented for the but the sliding scale was 350, - On 12/12/24 at 5:0 documented for the but the sliding scale was 350, - On 12/14/24 at 5:0 documented for the but the sliding scale was 350, - On 12/15/24 at 12 documented for the but the sliding scale was 349, - On 12/17/24 at 8:0 documented for the but the sliding scale was 350, - On 12/23/24 at 12 documented for the but the sliding scale was 350, - On 12/23/24 at 12 documented for the but the sliding scale was 304, - On 12/23/24 at 5:0			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) 95% compliance at the end of 6 months; then monitoring can stopped Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will hav been addressed. However, an patterns will be identified. Any Action Plan needed will be wri by the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved. By what date be completed? E of Compliance 2/24/25	the be	
	was 373, - On 12/29/24 at 7:0 documented for the	blood glucose documented O A.M., the blood glucose scheduled insulin was 376, blood glucose documented				
	· ·	00 P.M., the blood glucose				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155233		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	COME	E SURVEY PLETED D/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE		958	EET ADDRESS, CITY, STATE, ZIP C E HWY 46 'ESVILLE, IN 47006	COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE A	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAG	documented for the but the sliding scale was 350, On 01/23/25 at 12 documented for the but the sliding scale was 248, and On 02/01/25 at 5:0 documented for the but the sliding scale was 350. There was no indicate notified when the but greater than 350. During an interview LPN 6 (Licensed President received sliroutine insulin and reported to the physician was no indicate the physician was notified when the but greater than 350. During an interview LPN 6 (Licensed President received sliroutine insulin and reported to the physician was notified when the EN the physician was notified when the EN the physician was notified to the physician was not parameters to call the should have the sand documented and the if they were outsided. The current, undate "Change in Resider provided by the DC The policy indicate facility to ensure the physician and Representations and Represen	scheduled insulin was 376, blood glucose documented: 300 P.M., the blood glucose scheduled insulin was 435, blood glucose documented: 300 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 300 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 301 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 302 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 303 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 304 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 305 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 306 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 307 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 308 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 309 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 309 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 300 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 301 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 302 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 303 P.M., the blood glucose scheduled insulin was 415. blood glucose documented: 304 P.M., the blood glucose scheduled insulin was 415. blood gluc	IAU			DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	C/CLIA (X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00			COMPLETED	
		155233	B. WING			02/10/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE, THE			STREET ADDRESS, CITY, STATE, ZIP COD 958 E HWY 46 BATESVILLE, IN 47006					
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	3.1-50(a)(2)							

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