STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING 00 B. WING	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00382941. Complaint IN00382941- Substantiated. Federal/State deficiency related to the allegation is cited F926. Unrelated deficiency cited. Survey dates: September 9 and 12, 2022 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 38 Medicaid: 36 Other: 12 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 19, 2022.	F 0000		
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control guidelines were followed related to TBP (Transmission Based Precautions) for 5 of 8 staff observed related to Infection Control. (RN 6, Provider 1, CNA 2, LPN 9, and QMA 10) Findings include: During the initial tour on 9/9/22 at 10:01 a.m., the residents' rooms were observed to have a yellow stop sign on the doors indicating Personal Protective Equipment (PPE) of a N95 mask,	F 0880	**F880 Infection Control** 1. RN #6, LPN #8, LPN #9, C.N.A. #2 and provider #1 were all verbally re-educated by the Administrator regarding proper isolation precautions and use of PPE in isolation rooms during the survey. PPE cart was placed by room 313 and red zone areas. 2. Residents residing in the facility on 9/9/22 to 9/12/22 were identified by the Administrator as having the potential to be affected by facility adherence to	10/11/2022

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	eyewear, gown, and gloves were required. During an observation and interview on 9/9/22 at 10:13 a.m., Registered Nurse (RN) 6 entered isolation Room 222 without donning a gown or gloves. The RN indicated she had not donned a gown or glove to enter the resident's room. The residents room required TBP. During an observation and interview on 9/9/22 at 10:20 a.m., the Provider 1 was observed in an isolation room without a face shield, upon exiting she indicated she was not aware it was an isolation room. They missed the sign on the door due to the number of decorations on the resident's door. During an observation and interview on 9/9/22 at 10:23 a.m., Certified Nursing Aide (CNA) 2 was in isolation Room 313 wearing a surgical mask and eye wear. She indicated she did not see the sign on the door. There were no PPE carts available on the hallway. During an observation and interview on 9/9/22 at 10:28 a.m., Licensed Practical Nurse (LPN) 8 indicated the residents on the unit were in isolation precautions due to a resident had tested positive for covid. There were no PPE isolation carts on the hall. During an interview on 9/9/22 at 11:04 a.m., the Administrator indicated there were six positive residents that had been moved to the red zone. When staff entered an isolation room they were required to have on a gown, gloves, mask, and eyewear. During an observation and interview on 9/12/22 at 10:02 a.m., LPN 9 entered the isolation Room 308		appropriate infection control practices. A facility tour was completed by administrative staff and no other concerns were identified. 3. On 10/4/22, the Regional Nurse Consultant/Infection Control Preventionist and Director of Nursing /Infection Control Preventionist initiated education with facility staff regarding the proper infection control procedures, isolation precautions (including N95 masks), PPE (gowns/gloves/masks/face shields/goggles) and the availability of isolation carts. This education included PPE skills observation check-off to validate competency with use of PPE and handwashing competencies. On 9/12/22, the Administrator reviewed the policy and procedures for proper use of PPE (*Personal Protective Equipment).* No revisions were required. On 10/5/22 the annual facility infection control assessment will be reviewed and revised by the Director of Nursing/Infection control preventionist and the Executive Director. The facility will continue weekly infection control rounding tool that will be conducted by the infection control preventionist/designee to audit compliance with infection control and identify opportunities for education. *The weekly infection control rounds will be reviewed by*	

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	wearing only a mask. She indicated she did not don PPE. Qualified Medical Assistant (QMA) 10 was observed in the bathroom with a surgical mask under her chin, she indicated she had only pulled it down because Resident D could not hear her when she talked. A copy of the Yellow Stop Sign on the isolation room doors was provided by the Regional Administrator on 9/12/22 at 9:44 a.m. The sign indicated " ...Yellow Zone ...Transmission Base Precautions ...Contact Droplet ...PPE Required: N95 Mask ...Faceshield or Goggles ...Gown ...Gloves ..." The current facility policy titled "Infection Control" and not dated, was provided by the Regional Administrator on 9/12/22 at 3:35 p.m. The Policy indicated, " ...created to assist with achieving compliance ...pertaining to the ...prevention of infections ...Policy: ...the facility must have a system in place to control transmission of communicable diseases ..." 3.1-18(b)		*the administrator, DON and Regional Nurse consultant or Regional Operator weekly for additional guidance. The weekly infection control rounds will continue for a period of no less than 7 months.* *(Facility and Agency, Licensed nursing staff will not be allowed to work after October 11,2022, unless they have successfully completed all assigned education).* 4. On 10/4/22, an **Infection Control Quality Review Audit Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Infection Control Preventionist and Administrative staff will complete random PPE observations, using the Infection Control Quality Review Audit Tool, to validate that infection control procedures are followed. This audit will include monitoring for proper use of PPE and compliance with following isolation guidelines, handwashing, and use of appropriate masks. Any concerns identified during the infection control observations will be addressed at the time of the observation and additional education will be completed at that time. The Infection Control	

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			Quality Review Audit will be completed will be completed by auditors observing a minimum of five random staff members during each audit. The audits will be completed five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 20 staff observations will be reviewed monthly until 100% compliance has been determined by the QAPI committee*. (A minimum of seven months must be completed).* Date of Completion-10/11/22	
F 0926 SS=D Bldg. 00	483.90(i)(5) Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. Based on observations, interview, and record review, the facility failed to implement the smoking policy related to the resident's choice to smoke for 1 of 3 residents reviewed for smoking policy.	F 0926	**F926 Smoking Policies** 1. C.N.A #2 was verbally educated by the Administrator regarding smoking privileges for	10/11/2022

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	(Resident B) Findings include: During an interview on 9/9/22 at 9:38 a.m., Resident B's family member indicated the resident wanted to smoke and the facility staff were not taking him out to smoke. On her recent visit to the facility, she observed staff outside with two other residents and her family member was sitting at a table in the dining room and was not permitted to go outside to smoke. During an interview on 9/9/22 at 10:26 a.m., Certified Nursing Aide (CNA) 2 indicated there were only two residents who smoked on the dementia unit. At 10:35 a.m., CNA 2 indicated the only two residents' who smoked were Residents C and D. The residents' cigarettes were kept in the medication cart until it was time to go out. She would take them out to smoke when the nurse returned. During an observation and interview on 9/9/22 at 10:28 a.m., Licensed Practical Nurse (LPN) 3 indicated resident cigarettes were kept locked in the top drawer of the medication cart. She unlocked the top drawer of the medication cart and it contained three different packs of cigarettes. Resident B's name was on one of the packs. During an interview on 9/9/22 at 10:33 a.m., Resident B indicated he smoked and was ready to go smoke. The clinical record for Resident B was reviewed on 9/9/22 at 11:09 a.m. Diagnoses included, but were not limited to, dementia, depression, anxiety, restlessness, and agitation. A Quarterly Minimum		resident B during the survey. Resident B is approved for smoking privileges. 2. Residents residing in the facility 9/12/22 who are smokers were identified by Social Services and the Administrator as having the potential to be affected by facility adherence to the smoking policy and allowing smoking privileges. A facility tour was completed by administrative staff and no other concerns were identified regarding smoking privileges. 3. On 10/4/22, the Regional Nurse Consultant/Infection Control Preventionist and Director of Nursing /Infection Control Preventionist and Assistant Director of Nursing will initiate education with facility licensed and certified staff regarding the smoking policy and resident smoking privileges. Each staff member will be required to complete a posttest to ensure competency. On 9/12/22, the Administrator reviewed the policy and procedures for Smoking. No revisions were required. On 10/4/22 to 10/5/22 the Intradisciplinary team will review residents who smoke to ensure resident care plans are being followed and privileges are granted are consistent with each resident's plan of care.	

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	Data Set (MDS) assessment, dated 7/32/22, indicated the resident was severely cognitively impaired. A Physician's Order, dated 3/15/22, indicated the resident may smoke in accordance with the facility smoking policy. A Care Plan, with a revised date of 2/19/22, indicated Resident B was a smoker and goes out for supervised scheduled smoke breaks in designated area. The resident was educated on the smoking policy. The intervention was for the resident to be supervised during smoking. A Smoking Schedule was provided by the Administrator on 9/12/22 at 10:36 a.m. The scheduled smoking times were: 7:00, 10:00, 1:00, 4:00, 7:00, and 9:30. During an interview on 9/9/22 at 10:40 a.m., the Administrator indicated staff had been told Resident B was allowed to smoke during the scheduled smoke breaks. The current facility policy titled " Baseline Care Plan Assessment/Comprehensive Care Plans" and not dated, was provided by the Regional Administrator on 9/12/22 at 3:35 p.m. The Policy indicated, " ...intended to promote continuity of care and communication among ...staff ...interventions using the "Person-Centered" Plan of Care approach for each resident that includes ... mental and psychosocial needs ...The facility interdisciplinary team in ...along with a "hands on" caregiver, such as a Certified Nursing Assistant ...appropriate interventions ...in an effort to achieve ... overall well-being attainable for the resident ..."		*(Facility and Agency, Licensed nursing staff will not be allowed to work after October 11,2022, unless they have successfully completed all assigned education).* 4. On 10/4/22, a **Smoking Privilege Audit Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Administrator/ Designee will complete random smoking observations, using the Smoking Privilege Quality Review Audit Tool, to validate that smoking privileges are being followed based on resident's plan of care. This audit will include monitoring smoking observations and interviews on various days and shifts to ensure smoking privileges are continued based on each resident's plan of care. Any concerns will be addressed at the time of the observation and additional education will be completed at that time. The Smoking Privilege Quality Review Audit will be completed will be completed five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required,	

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	This Federal tag relates to Complaints IN00382941.		based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* Date of Completion-10/11/22	