STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00443395. Complaint IN00443395 -Federal/State deficiency related to the allegation is cited at F770. Survey dates: September 30 and October 1, 2024. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 4 Medicaid: 50 Other: 5 Total: 59 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 2024.	F 0000	**F000** Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on record review and interview, the facility failed to follow the physician's orders for obtaining laboratory services for 1 of 3 resident's reviewed for laboratory testing. (Resident B) Findings include:	F 0770	**It is the practice of this facility to follow physician orders and obtain laboratory service for residents.** What corrective action will be accomplished for those residents	10/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jalena Ball	Administrator	10/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The clinical record for Resident B was reviewed on 09/30/2024 at 9:23 A.M. An Admission MDS (Minimum Data Set) assessment, dated 09/11/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, Gastroesophageal reflux disease (GERD), and End Stage Renal Disease (ESRD). A physician's order, dated 09/11/24, indicated the staff were to obtain a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), and a BNP (B-type Natriuretic Peptide). During an interview with Resident B, on 09/30/24 at 3:27 P.M., she indicated a QMA (Qualified Medical Assistant) came into get her blood and was unsuccessful. She was told another nurse would come back and try, but nobody ever came back. During an interview with the Administrator, on 09/30/24 at 2:32 P.M., she indicated that she was unable to find a laboratory (lab) report for Resident B for 09/11/24. She believed the order was transcribed wrong and fell off the orders after 24 hours. The facility had no record of it being collected or the results of the tests. During an interview with LPN (Licensed Practical Nurse) 2, on 10/01/24 at 9:37 A.M., she indicated that when a physician ordered blood work on a resident the nursing staff would go and collect it the same day, and they would call the lab to come and pick it up. There was no reason an order should not have been collected. The current undated facility policy titled, "Physician Orders - (Following Physician		found to have been affected by the deficient practice. **Resident B no longer resides at the facility.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. **An audit of resident's lab orders was completed to ensure physician orders for labs have been followed by the Director of Nursing/Designee on 10/10/2024. Any concerns were addressed, and MD notified as needed.** What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. **Nursing education was on 10/1/24 by the DON to review the "Physician's Orders-Following Physician's orders" and "Lab Scheduling/Tracking" policy and procedure, to include obtain labs as ordered. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.**	

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	Orders)", was provided by the Administrator on 10/01/24 at 9:50 A.M. The policy indicated, " ...It is the policy of the facility to follow the orders of the physician ...". The current undated facility policy titled, "Lab Scheduling/Tracking", was provided by the Administrator on 10/01/24 at 9:50 A.M. The policy indicated, " ...It is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that ordered lab work is obtained ... ". This citation related to Complaint IN00443395 3.1-49(a)		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. **DON/Designee will implement an audit tool to monitor compliance with laboratory orders to ensure orders are completed. This audit will be completed 5x a week x4 weeks, then 3 x a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. . If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** By what date the systemic changes for each deficient will be completed. **October 21, 2024**	