STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428486. Complaint IN00428486 - Federal/state deficiencies related to the allegations are cited at F684. Unrelated deficiency is cited. Survey dates: March 4, 2024 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 44 SNF: 1 Total: 45 Census Payor Type: Medicare: 8 Medicaid: 29 Other: 8 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/5/24.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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

Kristina Herrera | Executive Director | 03/15/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure Physician's Orders for monitoring an external cardiac device were followed for 1 of 1 residents reviewed for specialty care. (Resident B) Finding includes: Resident B's record was reviewed on 3/4/24 at 9:55 a.m. Diagnoses included, but were not limited to, cerebral infarction, congestive heart failure, and cardiomyopathy. The Admission Minimum Data Set (MDS) assessment, dated 2/6/24, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, dated 2/3/24, indicated the resident had an external cardiac device. Interventions included, but were not limited to, every 24 hours change and recharge the batteries. A Physician's Order, dated 2/2/24, indicated to check external cardiac device placement every shift. A Physician's Order, dated 2/3/24, indicated to change the battery pack on the external cardiac device daily at 10:00 a.m., nurse to affirm vibration box located within the vest. The February and March 2024 Treatment Administration Record (TAR) indicated the external cardiac device placement check was not completed as ordered on the following days and	F 0684	F684 It is the intent of this facility is to ensure physician orders for monitoring an external cardiac device are followed. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident B had no negative outcome from this alleged deficient practice · The DON affirmed location and functioning of the vibration box on the resident's cardiac life vest. On 03/04/2024 No negative outcome. 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 with orders for specialty care devices including cardiac life vest have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility that have orders to monitor special care devices. The DON completed an audit identifying resident with orders for specialty devices on 03/07/2024	03/17/2024

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	shifts: - Day shift on 2/3/24 was left blank. On 2/29/24, the response was no. - Evening shifts on 2/3/24 and 3/1/24 were left blank. On 2/5/24, the response was no. - Night shifts on 2/2/24, 2/9/24, 2/11/24, and 3/1/24 were left blank. On 2/28/24, the response was no. The February 2024 TAR indicated, on 2/3/24 and 2/5/24 at 6:15 a.m., the Physician's Order to change the battery pack on the external cardiac device was not completed as ordered. During an interview on 3/4/24 at 11:40 a.m., the Director of Nursing indicated she believed the nurse did not chart on the TAR on the days that there was a QMA on the floor passing medications. Low batteries would have sounded an alarm, which would have alerted staff to check the monitor. The orders should have been followed and checked off as completed on the TAR. This citation relates to Complaint IN00428486. 3.1-37(a)		The DON affirmed location and functioning of the devices on residents that have orders to monitor. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced the nursing staff by 03/17/2023 on the following. 1 Following a physician's order 2 Monitoring specialty devices 3 Documentation for signing the MAR's and TAR's after medications and treatments are completed. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will audit MAR's and TAR's five times a weekly for completion on documentation x 4 weeks, then three times a week x 4 weeks, then once a week x 4 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	

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			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. 03/17/2024	
F 0880 SS=D 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 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,			

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	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 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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn before entering a COVID-19 positive resident room, droplet/contact isolation room, and hand hygiene not completed before donning PPE, for random observations for infection control on 1 of 3 units observed. Findings include: 1. During a random observation, Hospice Aid 1 entered Resident C's room on 3/4/24 at 10:47 a.m. The door had a sign indicating the resident was in droplet and contact isolation, as the resident had human metapneumovirus (an upper or lower respiratory disease). The sign indicated a gown, gloves, eye protection, and N95 mask were required to enter. Hospice Aid 1 entered the room without performing hand hygiene, and did not don any of the required personal protective equipment (PPE). At the time, Hospice Nurse 1 was observed talking to the resident at the bedside. She was not wearing any of the required PPE. 2. During a random observation on 3/4/24 at 10:49 a.m., Laundry Aid 1 entered Resident C's room. Laundry Aid 1 walked into the room carrying laundry, and did not put on an N95 mask, gown, gloves, or eye protection before entry. Laundry Aid 1 indicated she did not observe the sign before entry, but should have donned the appropriate protective equipment.	F 0880	F-880 It is the intent of this facility for the residents to ensure that infection control measures are in place and implemented, including those to prevent and/or contain COVID-19, ensure that staff wear personal protective equipment (PPE) in COVID positive, droplet/contact isolation rooms, complete hand hygiene before donning and doffing PPE. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents had any negative outcomes related to this alleged deficient practice. Hospice Aid 1, Laundry Aid, Speech Therapist 1, and Activity Aid 1 were educated on identifying PPE required, handwashing, donning and doffing, upon entering a room requiring PPE protection. 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 resident that resides in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility.	03/17/2024

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	3. During a random observation on 3/4/24 at 10:50 a.m., Speech Therapist 1 was observed entering Resident B's room. The door signage was marked droplet and contact isolation, as the resident was positive for COVID-19. The sign indicated a gown, gloves, N95 mask, and eye protection were required to enter. Speech Therapist 1 donned a gown, gloves, and N95 mask prior to entry. She did not put on any eye protection. Speech Therapist 1 indicated she only wore her glasses into the room, as there was no eye protection available in the supply container on the back of the door. The resident had been diagnosed with COVID-19 and that was the reason he was in isolation. 4. During a random observation on 3/4/24 at 11:07 a.m., the Director of Nursing (DON) was observed donning personal protective equipment (PPE) to enter Resident B's room. She donned a gown, gloves, and an N95 mask. She was not wearing any eye protection upon entering the room. During an interview on 3/4/24 at 11:50 a.m., the DON indicated she had a face shield in the resident's room, in a closet, that she would put on when she entered the room. She frequently entered the room to do Angel Rounds. 5. During a random observation, on 3/4/24 at 11:10 a.m., Laundry Aid 1 entered Resident C's room. Laundry Aid 1 walked into the room and did not put on an N95 mask, gown, gloves, or eye protection before entry. 6. During a random observation on 3/4/24 at 11:11 a.m., Activity Aid 1 was observed entering Resident C's room. She entered the room and did not put on an N95 mask, gown, gloves, or eye		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Regional Nurse Consultant in-serviced the Director of Nursing handwashing, Infection Control Policy, COVID 19 policy and isolation and PPE requirements on (DATE). The DON/Designee in-serviced all staffing departments on 03/15/2024 on the following. 1 Infection Control, Handwashing 2 Identification of PPE precautions and using the proper PPE 3 COVID 19 Policy 4 Isolation and PPE requirement Additionally, any staff member that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will complete Observation rounds to include hand hygiene and using proper PPE on 5 random facility staff members once a week x 4 weeks, then 3 random staff members x 4 weeks, then 2 random staff members monthly x 4 months. These Observations will be	

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	protection before entry. Activity Aid 1 indicated she did not know the resident was in isolation for anything, and she did not think she had to wear any type of personal protective equipment. During an interview on 3/4/24 at 11:50 p.m., the Director of Nursing indicated the appropriate PPE should have been worn into the isolation rooms. 3.1-18(b)		conducted on random shift and hallways. 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 resolve. Date of compliance 03/17/2024	