| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155053 | A. BUILDING 00<br>B. WING | 03/19/2024 |

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| WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE | 612 E 11TH ST<br>RUSHVILLE, IN 46173 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00428105 and IN00429415<br><br>Complaint IN00428105 --Federal/state deficiencies related to the allegations are cited at F757, F759 and F880.<br><br>Complaint IN00429415 --Federal/state deficiencies related to the allegations are cited at F757, F759 and F880.<br><br>Survey dates: March 18 and 19, 2024<br><br>Facility number: 000018<br>Provider number: 155053<br>AIM number: 100273930<br><br>Census Bed Type:<br>SNF/NF: 34<br>Residential: 13<br>Total: 47<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 23<br>Other: 5<br>Total: 34<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on March 27, 2024 | F 0000 | 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's date of alleged compliance is 4/12/24. The facility is respectfully requesting paper compliance for all deficiencies in this POC. | |
| F 0757<br>SS=D<br>Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Diana | Gore | 04/11/2024 |

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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| | Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on interview and record review, the facility failed to ensure a prescription narcotic was not administered to a resident without an appropriate prescription for the narcotic for 1 of 6 residents reviewed for correct receipt of medications. (Resident C)<br><br>Findings include:<br><br>In an interview on 3-19-24 at 9:27 a.m., with a family member of Resident C, she indicated she remained upset that it took over 14 hours before family was notified of the medication error. "They told me the nurse did not tell them and they did not find the error until the next day and that I was notified as soon as they were made aware of the error." | F 0757 | **F 757 Unnecessary Drugs:**<br>It is the policy of this facility to ensure prescription narcotics are not administered to a resident without am appropriate prescription.<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident C was assessed and monitor on 2/25/2024 with no negative outcome related to this alleged deficient practice.<br>**How other residents having the potential to be affected by the same deficient practice will be** | 04/12/2024 |

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| | A progress note for Resident C, dated 2-26-24 at 2:40 p.m. indicated, "NP [nurse practitioner] approached AODN [Assistant Director of Nursing] this shift, res [resident] has stated to NP that she had received 2 Tramadol at HS [bedtime] on 2-25-24, ADON [Assistant Director of Nursing] confirmed that res did received [sic] medications, vs [vital signs] obtained, POA [power of attorney], admin [administrator], DON [Director of Nursing], notified, will cont [continue] to monitor for adverse reactions."<br><br>A progress note, dated 2-27-24 at 3:50 p.m. indicated, "IDT [interdisciplinary team] met to address root cause of medication error. Resident was given roommate's medication in error. Nurse counseled on medication error. Resident monitored for adverse effects."<br><br>In an interview with the Administrator on 3-19-24 at 12:35 p.m., she indicated the facility was unaware of the medication error until the next day (2-26-24). "Apparently [name of Resident C] told the nurse practitioner she had slept really well from the two Tramadol tablets she had received the night before. She did not have an order for Tramadol. I can't remember if the Tramadol belonged to her roommate or another resident with the same first name."<br><br>In an interview with the Corporate Nurse on 3-19-24 at 4:55 p.m., she indicated Resident C did not have any negative outcomes from the Tramadol. The Corporate Nurse confirmed the facility thinks the medication (Tramadol) was from the resident's roommate, medication supplies. The Corporate Nurse provided a copy of Resident J's "Controlled Drug Receipt Record/Disposition Form" for her Tramadol 50 milligram (mg), with instructions listed as, "take 2 tablets (100 mg) by | | **identified and what corrective actions will be taken?**<br>The DON/Designee completed an audit on 4/10/24 of residents narcotics and verified they had an appropriate prescription.<br>**What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?**<br>The DON/Designee in-serviced the nursing staff on policy Medication administration on 4/10/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.<br>**How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked)**<br>Medication administration observation will be completed by the DON/Designee.<br>DON/Designee will audit 5 random nurse/QMA weekly for 4 weeks, then 3 random nurse/QMA weekly for 4 weeks, then 2 random nurse/QMA weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If | |

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| | mouth every 12 hours (scheduled)," for dates 2-22-24 to 2-28-24. This form indicated two entries for 2-25-24 at 11:00 p.m., which indicated 2 tablets had been used for both entries, with one of the entries indicating the dose had been destroyed by the administering nurse and co-signed by another staff member as a destroyed dose. When the Corporate Nurse provided the copy of the form, she indicated, "You will notice there were two doses signed out for 2-25-24 at 11 p.m." No explanation was provided as to why the initial dose documented on 2-25-24 at 11:00 p.m. was documented as "destroyed."<br><br>A review of the clinical record for Resident C was reviewed on 3-18-24 at 3:44 p.m. Her diagnoses included, but were not limited to an unspecified fracture of the left pubis (pelvic fracture). Her admission Minimum Data Set assessment, dated 2-20-24, indicated she was cognitively intact. A review of her physician orders reflected Resident C had no orders for Tramadol at the time she received the medication.<br><br>On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a policy, dated February, 2017, and entitled, "Medication Administration." This policy indicated its purpose as, "To administer all medications safely and appropriately." It indicated, "Review the resident's Medication Administration Record (MAR)...Identify resident before administering medication. Explain to resident the type of medication to be administered...Observe the resident for medication side effects and inform the physician if any occur. Document in Nursing Notes."<br><br>This Federal tag relates to Complaints IN00428105 and IN00429415. | | necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.<br><br>**By what date the systemic changes will be completed?**<br>Date of Compliance: April 12, 2024 | |

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| F 0759 SS=D Bldg. 00 | 3.1-48(a)(4)<br><br>483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>Based on observation, interview and record review, the facility failed to ensure their medication administration error rate remained under five (5) percent during 3 observations with 4 staff and 11 residents. (Residents E,and G)<br><br>Findings include:<br><br>1. During a medication pass observation on 3-18-24 at 4:50 p.m., with Resident E, RN 4 was observed to administer one tablet of omeprazole 20 milligrams (mg). Upon reconciliation of Resident E's physician orders, the order indicated to administer omeprazole 20 mg in the evening at 3:00 p.m. This indicated the medication was given outside of the accepted practice of medications being administered within one hour before or after their scheduled time. In an interview with RN 5 on 3-19-24 at 8:40 a.m., she indicated it was facility policy to administer medications within a one hour window of the scheduled medication administration time.<br><br>2. During a medication pass observation on 3-18-24 at 4:59 p.m. with Resident G, RN 4 was observed to administer 4 units of Humalog insulin via a Humalog Kwikpen device subcutaneously into the right deltoid. RN 4 was observed to remove the needle immediately from the skin upon completion of the injection. When queried in | F 0759 | **F 759 Medication Errors 5 pct or More:**<br>It is the policy of this facility to ensure medication administration error rate remains under 5 percent.<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident E and G were assessed by the nurse on 3/18/2024 and the residents had no negative outcome related to the alleged deficient practice.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents in the facility.<br><br>**What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** | 04/12/2024 |

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| | regard to this practice, she indicated she was unaware the needle should remain in place for several seconds after the injection.<br><br>3. The medication pass observation rate, calculated on 27, opportunities for errors with 2, actual errors, resulted in a medication administration error rate of 7.4 percent.<br><br>"Humalog KwikPen" (revised July, 2023) was retrieved on 3-20-24, from the Lilly Pharmaceutical web site. In the section specific to how to use the KwikPen, step 11, indicates, "Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle."<br><br>On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a guideline entitled, "Guidelines for Insulin Pens," dated 8-10-23. This document indicated, "It is the intent of the facility to monitor, maintain and administer insulin, to include insulin in INSULIN PENS per manufacturer's recommendations and peer physician order." This document did not address any issues with length of time the needle should remain in the skin upon administration. The facility did not provide any manufacturer's recommendations for this particular KwikPen.<br><br>This Federal tag relates to Complaints IN00428105 and IN00429415.<br><br>3.1-48(c)(1) | | The DON/Designee in-serviced the nurses and QMA's on the policy Medication Administration on 4/10/24. The DON/Designee in-serviced the nurses on the Guidelines for Insulin Pens on 4/10/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.<br>**How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked)**<br>Medication administration audits for insulin administration and medications administered within the one hour before and one hour after the scheduled time of the medications, the observations will be completed by the DON/Designee. DON/Designee will audit 5 random nurse/QMA weekly for 4 weeks, then 3 random nurse/QMA for weekly x 4 weeks, then 2 random nurse/QMA weekly x 4 months.<br>If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 | |

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| | | | written Action Plan will be monitored by the Administrator weekly until resolution.<br><br>**By what date the systemic changes will be completed?**<br>Date of Compliance: April 12, 2024 | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must | | | |

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| | include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | | | |

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| | The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, interview and record review, the facility failed to ensure infection control measures of handwashing and hand-hygiene were utilized during a medication pass administration observation conducted during 3 observations with 4 staff and 11 residents. (Residents E, F and G, )<br><br>Findings include:<br><br>During a medication pass observation on 3-18-24 between 4:50 p.m. and 5:00 p.m., RN 4 indicated she wears gloves for medication passes. Upon completion of medication administrations to Residents E, F and G, RN 4 was observed to remove and discard her gloves, then obtain a single alcohol pad and wipe the palm of each of her hands with the alcohol pad. When queried about this practice, RN 4 responded she did not have any alcohol hand-sanitizer on her medication cart and the large container of alcohol hand-sanitizer was located on the desk at the nurse's station.<br><br>In an interview on 3-19-24 at 12:35 p.m., with the Administrator, the Administrator was informed of concerns related to handwashing and hand-hygiene practices during a medication pass observation on 3-18-24, with RN 4. The Administrator was notified of concerns related to RN 4, cleansing her hands post glove removal by using a single alcohol wipe to cleanse only the palms of her hands. RN 4, explained she did not use alcohol hand-sanitizer as the only bottle was located at the nurse's station. The Administrator indicated she maintains a supply of personal-sized bottles of alcohol hand sanitizer readily available | F 0880 | **F880 Infection Control:**<br>It is the policy of facility to maintain infection control measures of handwashing and hand-hygiene during medication pass administration.<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were affected by this alleged deficient practice.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents in the facility.<br><br>**What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?**<br>The DON/Designee in-serviced the nurses and QMA's on Medication Administration and Hand Hygiene on 4/10/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. | 04/12/2024 |

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| | for use and indicated she (the Administrator) was in the building and available during the 3-18-24 medication pass observation.<br><br>On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a policy entitled, "Medication Administration," dated February 2017. This policy indicated its purpose as, "To administer all medications safely and appropriately." It indicated, "Wash hands before beginning, whenever you contaminate your hands, and if contact is made with the medication." This policy did not address the use of alcohol-based hand-sanitizer during a medication pass.<br><br>"CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings," (November, 2022) was retrieved on 3-20-24 from the Centers of Disease Control (CDC) website. The guidance indicated the following information:<br>"-Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations.<br>-Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient ' s immediate environment; After contact with blood, body fluids or contaminated surfaces; Immediately after glove removal.<br>-Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled.<br>-Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas | | **How the corrective actions will be monitored to ensure the deficient practice will not recur? (what QA program will be put into place and how often checked)**<br>Medication administration audits for hand hygiene during medication adminsitration, the observations will be completed by the DON/Designee.<br>DON/Designee will audit 5 random nurse/QMA weekly for 4 weeks, then 3 random nurse/QMA for weekly x 4 weeks, then 2 random nurse/QMA weekly x 4 months.<br>If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will 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 Administrator weekly until resolution.<br><br>**By what date the systemic changes will be completed?**<br>Date of Compliance: April 12, 2024 | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE | 612 E 11TH ST<br>RUSHVILLE, IN 46173 |

| (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 |
|---|---|---|---|---|
| | where patient care is being delivered."<br><br>This Federal tag relates to Complaints IN00428105 and IN00429415.<br><br>3.1-18(l) | | | |