STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 00 B. WING	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00410173. Complaint IN00410173 - No deficiencies related to the allegations are cited. Survey dates: August 29, 30, 31, 2023 and September 1, 2023. Facility number: 000342 Provider number: 155573 AIM number: 100289140 Census Bed Type: SNF/NF: 22 Total: 22 Census Payor Type: Medicare: 1 Medicaid: 17 Other: 4 Total: 22 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 6, 2023	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 9/20/2023 Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use			

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

Sarah Jackman | HFA | 09/23/2023

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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	personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to ensure a foley catheter drainage bag was covered, to provide dignity, for a resident with a foley catheter for 1 of 1 residents reviewed for catheters. (Resident 75) Findings include: Resident 75's record was reviewed on 8/30/23, at 1:23 p.m. The record indicated Resident 75 had diagnoses that included, but were not limited to, bone infection of the lower vertebra, protein-calorie malnutrition, type 2 diabetes mellitus, heart disease, pressure ulcer of the sacral region, chronic kidney disease, heart disease and high blood pressure. A care plan, dated 8/24/23, indicated a focus for at risk for complications related to foley catheter use, and included, but was not limited to interventions of "monitor position of drainage bag and keep below waist to ensure proper drainage." Current physician's orders included: "Catheter care every shift and ensure catheter drainage bag is below the waist and covered every shift". With a start date of 8/23/2023 On 8/31/23, at 10:08 a.m., the catheter drainage bag was observed uncovered, and hung on the bed frame on the side of the bed that faced the door. On 8/31/23, at 11:46 a.m., the catheter drainage bag was observed uncovered on the side of the bed that faced the door.	F 0557	It is the policy of the facility that the facility to keep catheter drainage bag covered for residents' dignity. Resident #75 had dignity bag placed during survey. Resident #75 Foley catheter drainage bag was changed to a fig leaf cover bag on 9/5/2023. All residents that have a catheter drainage bag have the potential to be affected by this practice. Facility wide audit was completed on 9/18/2023 by DON to confirm all residents with a catheter bag have a dignity bag in place. The DON/Designee educated Nursing staff on the catheter drainage bag policy related to dignity bags by or on 9/14/2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. DON/Designee will complete Dignity Bag Audit 5 days a week for 4 weeks, 3 days a week for 4 weeks, then weekly for 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 have been addressed. However, any patterns will be identified. Any needed Action Plan will be written	09/20/2023

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	On 8/31/23, at 11:49 a.m., LPN 1 indicated they usually have a bag covering the catheter bag. LPN 1 checked the resident's catheter drainage bag, removed a dignity cover that was attached to the bed frame on the window side of the bed, and placed the catheter bag in it. A policy for catheter use was provided by the Administrator on 9/1/23 at 1:57 p.m. The policy included, but was not limited to: "...4. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques...." 3.1-3(v)(1)		by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
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 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 interview and record review, the facility failed to assess and document bruising on a cognitively impaired resident for 1 of 2 residents reviewed. (Resident 74) Findings include: During an interview, on 8/29/23, at 1:36 p.m.,	F 0684	It is the policy of the facility to assess and document bruising on cognitively impaired residents. Resident #74 was assessed and documentation was completed on the identified bruise to the back of the residents hand on September 1, 2023 by charge nurse. All residents that currently reside in the facility have the potential to	09/20/2023

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	Resident 74 indicated he had a bruise on his left wrist and doesn't know how he got it. The left wrist was observed to have a purple bruise that was slightly larger than a half dollar. Resident 74's record was reviewed on 8/30/23 at 2:23 p.m. The record indicated Resident 74 had been admitted on 8/25/23 and had diagnoses that included, but were not limited to, low back pain, permanent atrial fibrillation, heart disease, Alzheimer's disease, high blood pressure and presence of a cardiac pacemaker. Review of Daily Skilled Nursing Notes dated 8/26/23, 8/27/23, 8/28/23, 8/29/23, and 8/30/23, indicated no skin issues were assessed or documented, including bruising. There was no documentation in the progress notes of the bruising. On 9/01/23, at 1:05 p.m., Resident 74's left wrist was observed with the Director of Nurses and the Administrator. Resident 74 had two bruises; the bruise on his wrist and another bruise on the back of his hand/wrist area. The Director of Nurses indicated the newer bruise was from a blood draw and the bruise had a needle puncture wound. The bruise that had been observed earlier had dark purple undertones with reddened areas on top. Resident 74 indicated he didn't know how it happened. A policy for Skin Observation/Assessment, was provided by the Administrator on 9/1/23 at 1:57 p.m. The policy included, but was not limited to: "It is the policy of the facility to ensure that each resident is provided with showers and or baths to maintain proper hygiene as well as comfort. During the shower/bath, the care giver will		be affected. A Facility wide skin sweep was completed on 9/7/2023 by DON and ADON to identify any bruising not previously documented. DON/Designee will assess all new admissions/readmissions for skin issues and complete Shower Sheet Audit to identify any new skin issues. The DON/Designee educated the nursing staff were on skin observation/assessment on 9/14/2023. (Attachment A) Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. DON/Designee will complete Skin Audit and review new admissions/re-admissions 5 days a week for 4 weeks, 3 days a week for 4 weeks, then weekly for 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 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.	

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	observe the resident's skin. Conditions that will be observed for include but are not limited to what appear to the care giver to be cruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other conditions of the skin. Note: Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain any needed orders for treatment. Appropriate documentation and care planning will be completed as per policy...4.) Other times that will resident will have a skin assessment will be upon admission, readmission, after a fall or an injury, upon discovery (by a care giver) of a skin change, prior to discharge or as indicated with a condition change...." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition			

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	demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to ensure a resident had a physician's order for a foley catheter for 1 of 1 residents reviewed for foley catheter use. (Resident 75) Findings include: During an interview, on 8/30/23, at 10:34 a.m., Resident 75 indicated she has a catheter because she "can't go", and will have to have it for the rest of her life. A urinary catheter drainage bag was observed attached to the bed frame. Resident 75's record was reviewed on 8/30/23 at 1:23 p.m. The record indicated Resident 75 had diagnoses that included, but were not limited to, bone infection of the lower vertebra, protein-calorie malnutrition, type 2 diabetes	F 0690	It is the policy of the facility to ensure residents have physicians order for all foley catheters. Resident #75 physician orders were updated on September 1, 2023 to include the size of balloon and catheter. All residents that currently reside in the facility that have a foley catheter have to potential to be affected by this. Facility wide audit was completed on 9/18/2023 by DON and ADON to verify all residents with catheters have physician orders that includes the size of balloon and size of catheter. Physician Orders related to size of balloon and catheter audit will be completed to ensure all orders have this information. All	09/20/2023

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	mellitus, heart disease, pressure ulcer of the sacral region, chronic kidney disease, heart disease, and high blood pressure. A Care Plan, dated, 8/24/23, indicated a focus for at risk for complications related to foley catheter use, and included, but were not limited to interventions to "Monitor position of drainage bag and keep below waist to ensure proper drainage...Monitor indwelling catheter and change foley bag as needed. Change foley every month as ordered...." Current physician's orders included: "Catheter care every shift and ensure catheter drainage bag is below the waist and covered every shift", with a start date of 8/23/2023. "Monitor Foley Catheter output every shift every 8 hours" started 8/23/23. Physician's orders failed to include the size of the Foley catheter and how many cubic centimeters of water would be used to inflate the balloon to anchor the catheter in place in the bladder. On 9/01/23, at 1:34 p.m., the Administrator indicated the order for the catheter was not in the record, but they put it in. A policy for catheter use was provided by the Administrator on 9/1/23 at 1:57 p.m. The policy included, but was not limited to: "It is the policy of the facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that Catheterization was necessary...4. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention		nursing staff were reeducated by DON/Designee on the Catheter Policy related to Physicians orders including size of balloon and size of catheter on 9/14/2023. (Attachment A). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The DON/Designee will complete the Catheter Audit Tool to confirm all physicians' orders have the size of balloon and size of 5 days a week for 4 weeks, 3 days a week for 4 weeks, then weekly for 4 months. (Attachment A) 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.	

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	and control techniques...." 3.1-41(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview, observation, and record review, the facility failed to ensure oxygen tubing was dated for 1 of 1 residents reviewed for oxygen therapy. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 8/30/2023 at 1:35 p.m. The medical diagnoses included weakness, stroke, and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set Assessment, dated for 8/2/2023, indicated Resident 7 was cognitively intact, utilized oxygen therapy, and needed assistance from staff members for activities of daily living. A physician order, dated 4/25/2023, indicated for Resident 7 to utilize oxygen at 1 liter per minute continuously.	F 0695	**It is the policy of the facility that the facility dates all oxygen tubing. Resident #7 oxygen tubing was replaced and tubing was dated during annual survey.** **All residents that currently reside in the facility and receive oxygen therapy have the potential to be affected by this practice. A facility wide audit was completed on 9/7/2023 to ensure all residents that require oxygen have a current date on their oxygen tubing.DON/Designee will complete The Oxygen Tubing Dated audit verify oxygen tubing is dated. All nursing staff we reeducated on the oxygen policy related to dating tubing on 9/14/2023.** Additionally, any employee who fails to comply with	09/20/2023

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	During an observation and interview on 8/29/2023 at 11:07 a.m., Resident 7 was laying in bed at this time with her oxygen nasal cannula on the floor. The oxygen tubing and humidification bottle did not have a date of initiation on it. Resident 7 reported she did not know the last time her oxygen tubing was changed, but it was on the floor because it falls off when she sleeps. During an observation on 8/29/2023 at 2:24 p.m., Resident 7 was laying in bed with her oxygen nasal cannula on the floor. The oxygen tubing and humidification bottle did not have a date of initiation on it. Resident 7 reported she put her oxygen back in when she was eating lunch, but it had fallen off again. A policy entitled, "Oxygen Administration", was provided by the Administrator on 8/31/2023 at 12:00 p.m. The policy indicated, " ...Tubing, humidifier bottle and filters will be changed, cleaned and maintained no less than weekly and PRN [as needed]. Each will be labeled with the date, time, and initialed by staff completing this service to equipment ..." 3.1-47(a)(6)		the points of the in-service may be further educated and/or progressively disciplined as indicated. **DON/Designee will complete the Oxygen Tubing Dated audit 5 days a week x 4 weeks, 3 days a week x 2 months, then weekly 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 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.	