STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00452209 and IN00453443. Complaint IN00452209 -- No deficiencies related to the allegations are cited. Complaint IN00453443 -- Federal/state deficiency related to the allegations is cited at F760. Unrelated deficiencies are cited. Survey dates: February 19, 20 and 21, 2025 Facility number: 000018 Provider number: 155053 AIM number: 100273930 Census Bed Type: SNF/NF: 46 Residential: 9 Total: 55 Census Payor Type: Medicare: 9 Medicaid: 32 Other: 5 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 26, 2025.	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 March 14, 2025. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana Gore	Administrator	03/06/2025

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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	Based on interview and record review, the facility failed to ensure a resident who was admitted to the facility with a pressure ulcer received thorough assessment upon admission, initiated a treatment timely for an identified pressure ulcer, and initiated treatment changes per the wound provider promptly for 1 of 3 residents reviewed for pressure ulcers. (Resident C) This deficient practice was corrected on 2/14/25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policy and procedure regarding pressure ulcers, reviewed all wound reports from the wound care provider for January and February of 2025 to identity potential residents, and conducted a review of residents with pressure ulcers to ensure assessments have been completed and documented with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: The clinical record of Resident C was reviewed on 2/20/25 at 10:00 a.m. The diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, congestive heart failure, and hypertension. Resident C was admitted to the facility on 2/4/25. An Admission Minimum Data Set (MDS), dated 2/8/25, indicated one unstageable pressure ulcer was noted. An admission nursing assessment, dated 2/5/25, indicated a pressure ulcer to the left heel with no	F 0686	Past non-compliance: No plan of correction required	03/14/2025

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	further information regarding description, measurements, odor, drainage, and/or wound characteristics. There was noted redness and excoriation to the left and right buttock with no further description, measurements, odor, drainage, and/or wound characteristics. A skin integrity care plan, dated 2/10/25, indicated Resident C had a pressure ulcer to the right buttock. The interventions included, but were not limited to, provide treatment per physicians' order. A Wound Assessment Report, dated 2/7/25, indicated a stage 3 pressure ulcer to the right buttocks. The pressure ulcer contained 80% granulation tissue, 20% slough tissue, and measured 2.5 centimeters (cm) x 2.5 cm x 0.1 cm in depth. The treatment was listed to cleanse the wound with wound cleanser, apply medical grade honey, apply a bordered foam dressing, and change daily. The medication administration record (MAR), dated February 2025, did not reflect a treatment to the right buttock until 2/10/25. A physician order, dated 2/10/25, indicated the utilize medical grade honey, an abdominal pad, and bordered foam to bilateral buttocks daily. The order was discontinued on 2/13/25. The MAR, dated February 2025, indicated the treatment of the bilateral buttocks with medical grade honey was not signed off, as ordered, on 2/10/25 and 2/13/25. A Wound Assessment Report, dated 2/11/25, indicated a stage 3 pressure ulcer to the right buttocks and the pressure ulcer was improving without complications. The treatment was noted			

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	to cleanse the pressure ulcer with soap and water, pat dry, and apply triad, and leave open to air. A physician order, dated 2/13/25, indicated to cleanse the right buttock with soap and water, pat dry, apply triad paste, and leave open to air three times daily. An interview conducted with the Director of Nursing (DON), on 2/21/25 at 10:21 a.m., indicated the facility recognized the concern related to the lack of wound assessments, follow up pertaining to the wound care provider, and treatment completion. The DON indicated she was out "on leave" and the Assistant Director of Nursing (ADON) was overseeing the DON duties while the DON was out on leave. The ADON did not ask for assistance in covering the daily duties during the DON absence. There was an abrupt departure of the ADON, Scheduler, and a few staff nurses. The DON was working on the floor to cover staffing and did not have the time to work on the wound report. A policy entitled Guidelines For Prevention/Treatment of Pressure Injuries, dated 2019, was provided by the DON on 2/20/25 at 4:30 p.m. The policy indicated the following, "...If upon any assessment an actual pressure ulcer/pressure injury is found immediate steps will be taken to ensure that all notifications to the physician and the resident and the resident's Responsible Party/POA [power of attorney] are made. Also, to ensure that a treatment is in place as well as any appropriate interventions related to area(s)... A trained clinician in staging will assess the wounds and record dimensions to include length, width, and depth. The wound bed and the peri-wound will be assessed and described. Any odor or drainage will be described... Treatment of Pressure			

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	Injuries... whether identified on admission or readmission or after admission or readmission have the factors that influenced its development defined. This will allow appropriate interventions to be put into place to guard against further development of more areas or worsening of current area(s)...." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure 3 of 3 residents reviewed for falls had a minimum of 72 hours post-fall assessments, including neurological (neuro) checks as appropriate. (Residents B, F and G) Findings include: 1. The clinical record of Resident B was reviewed on 2-19-25 at 2:56 p.m. His diagnoses included, but were not limited to, alcohol dependency with unspecified withdrawal, weakness, difficulty in walking and repeated falls. An admission note, dated 1-23-25 at 10:43 p.m., indicated he was weak and unsteady with his balance and gait. A fall risk assessment, dated 1-23-25, indicated he was at high risk for falls. His Admission Minimum Data Set (MDS) assessment, dated 1-27-25, indicated he was moderately cognitively impaired, and he had sustained falls in the one month and two to six month time periods prior to admission. Resident B's care plans addressed both cognitive impairments and being at risk for falls. A nursing progress note, dated 1-28-25 at 5:45 a.m., indicated Resident B sustained an	F 0689	p="" paraid="58928983" paraeid="{8ebae2a8-368c-4716-be90-66198ac55501}{51}">F 689 - Free of accidents hazard/Supervision/Devices It is the policy of this facility to ensure a minimum of 72 hours post fall assessments and neurological checks are completed. What corrective action will be accomplished for those residents found to have been affected by deficient practice?¿ ¿ ¿Resident B no longer resides at the facility. The DON/Designee assessed residents F and G on 3/5/25 and no negative outcomes related to cited practice. ¿ 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 that reside in the facility have the potential to be affected by the alleged deficient practice, therefore, this plan of correction	03/14/2025

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	unwitnessed fall and was found lying on the floor of his room, but was unable to identify what he was doing prior to the fall and appeared disoriented. It indicated he was alert to person only. A review of the fall investigation, dated 1-28-25, included a document entitled, "Post Fall 72-hour Monitoring Report." It indicated, "This assessment should be completed at the following intervals for follow up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. Initial assessment (B) [baseline]; followed by q15 min [every 15 minutes] x4 [for first hour post fall], q30 min x2 [for second hour post fall]; every hour x2 [for hours 3 and 4 post-fall]; [then] once per shift for 72 hours [post fall]." The document reflected Resident B's neuro checks were initiated at 5:45 a.m. and continued at 6:00 a.m., and lastly at 6:15 a.m., with no changes denoted in neurological status or vital signs. No additional entries were documented regarding Resident B's neurological status or vital signs after 6:15 a.m., on this document. No additional progress notes to reflect Resident B's general status following his earlier fall were located in the clinical record until 1-28-25 at 7:45 a.m. A nursing progress note, dated 1-28-25 at 7:45 a.m., indicated, "This nurse was called to residents room at 7:15 Am by CNA who was delivering breakfast tray. Resident was found to be without a pulse and no respiration. CPR [cardiopulmonary resuscitation] was performed by staff till [sic] medics arrived on scene." It indicated Resident B was pronounced deceased at 7:36 a.m., by the emergency medical services team.		applies to all residents that reside in the facility. 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 nurses on the following policies, to include 72-hour post fall assessment and neuro checks. Guidelines for Incidents/Accidents/Falls Acciden ts and Incident: Neurological Check Guidelines ul="" role="list" Neuro Check Form Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. ¿ How the corrective action will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place.¿ ¿ The DON/Designee will audit falls five times a week x 4 weeks for 72 hours post a fall assessment and neuro checks, then 3 times¿x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months the monitoring will 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 Action Plan needed will be written by the QAPI committee. Any	

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	A documented handwritten "Timeline," dated 1-28-25, but unsigned by facility staff, indicated Resident B had been observed on 1-28-25 at 6:10 a.m., by Staff 4, "sleeping/snoring," in his recliner and by Staff 5, on 1-28-25, at approximately 7:00 a.m., to speak with the staff member, while in his chair. In an interview on 2-20-25 at 10:56 a.m., with the Director of Nursing (DON), she indicated she was not present at the facility on 1-28-25. "I did not locate any neurochecks; the nurse [LPN 6] did not do any neurochecks. She said she was not aware to do this; our policy is to conduct neurochecks on any unwitnessed fall and she was inserviced on this." 2. The clinical record of Resident F was reviewed on 2-20-25 at 9:34 a.m. His diagnoses included, but were not limited to diabetes, a rare genetic autoimmune disorder, weakness, fatigue, unspecified dementia, difficulty in walking and a need for personal care assistance. His most recent Minimum Data Set (MDS) assessment, an annual assessment, dated 1-23-25, indicated he was severely cognitively impaired, was dependent on staff for toileting needs, required substantial assistance with bathing and hygiene, required moderate assistance for mobility, transfers and walking, and used a walker or wheelchair for mobility. It indicated he had two or more falls since his last MDS assessment. It indicated he was receiving physical therapy services from the facility. A review of falls for the time period of 1-1-25 through 2-19-25, indicated Resident F had multiple falls without injury during this time period with three of the falls having incomplete documentation of his 72 hour post fall status, as		written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed? ul="" role="list" ul="" role="list" **March 14, 2025** Date: 3/14/25	

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	follows: - A nursing progress note, dated 1-10-25 at 6:53 p.m., indicated Resident F was heard calling out for help. When staff arrived to assist the resident, he was witnessed sliding out of his recliner. The resident was unable to explain what he was doing prior to his fall from his recliner. The note indicated he was assessed to have no injuries and had no change in his prior condition. An interdisciplinary note, dated 1-14-25, as a review of his fall, indicated the root cause of the fall was he slid out of his recliner. In an interview with the Director of Nursing (DON) on 2-21-25 at 1:10 p.m., she indicated she was unable to locate any documentation of monitoring conducted for 72 hours after this fall. - A fall investigation record, dated 1-31-25 at 5:12 a.m., indicated Resident F sustained an unwitnessed fall and was found lying on the floor in his room. It indicated Resident F was unable to explain what he was doing prior to being found on the floor. It indicated he did not sustain any injuries at that time. This document did not address his mental status, his mobility status, and identified predisposing physiological or situational factors only as, "Other," with no further explanation. The accompanying, "Post Fall 72-hour Monitoring Report," dated 1-31-25, indicated the fall occurred 1-31-25 at 4:30 a.m. This document indicated, "This assessment should be completed at the following intervals for follow up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. Initial assessment (B) [baseline]; followed by q15 min [every 15 minutes] x4 [for first hour post fall], q30 min x2 [for second hour post			

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	fall]; every hour x2 [for hours 3 and 4 post-fall]; [then] once per shift for 72 hours [post fall]." The document reflected Resident F's neuro checks were initiated at 4:30 a.m. and continued through 1-31-25 at 8:30 a.m. This form failed to specify any assessments conducted in regards to Resident F's cognition or skin status. A progress note, dated 1-31-25 at 2:00 p.m., indicated neurological checks continued and were within normal range. However, it was noted Resident F had a "hematoma to his forehead, an abrasion to the bridge of his nose, bruising to his left hand and a s/t [skin tear] to his L [left] arm, and abrasion to his L knee." A progress note, dated 1-31-25 at 2:05 p.m., indicated the physician was made aware of the changes to Resident F's status. In an interview with the DON on 2-21-25 at 1:10 p.m., she indicated the 72 hour post fall report was incomplete. -A nursing progress note, dated 2-15-25 at 1:40 p.m., indicated Resident F had a witnessed fall from his wheelchair with staff present at 11:00 a.m. It indicated he did not strike his head when he fell to the floor. A corresponding fall investigation, indicated Resident F had a witnessed fall on 2-15-25 at 11:00 a.m., while being pushed in his wheelchair by facility staff. It indicated the fall occurred when the resident put his feet down onto the floor, causing him to fall forward onto his knees. The resident was unable to offer any explanation of the event when requested to do so by staff. Resident F was assessed post fall and was identified with an abrasion to the left lower leg and swelling to the right lower leg. A corresponding "Post Fall 72-hour Monitoring Report" was not provided by the facility. 3. The clinical record of Resident G was reviewed on 2-21-25 at 11:30 a.m. Her diagnoses included,			

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	but were not limited to coronary artery disease, recent femoral artery graft with infection, arteriosclerotic heart disease, diabetes, peripheral vascular disease, anxiety and depression. Her Admission Minimum Data Set (MDS) assessment, dated 1-22-25, indicated she was cognitively intact, used a walker for mobility, required moderate assistance with bed mobility, transfers, walking, toileting, bathing and hygiene. It indicated she had no falls or fractures in the six months prior to her admission to the facility. In an interview with the Executive Director on 2-19-25 at 3:50 p.m., she provided a copy of a document which indicated Resident G had a fall on 1-26-25. The Executive Director indicated the facility did send Resident G to the local emergency room and a chest x-ray indicated she did have a rib fracture, but its origin was of an indeterminate date. A review of the fall investigation indicated Resident G sustained an unwitnessed fall on 1-26-25 at 2:07 p.m. It indicated staff heard the resident yelling in her room and found her lying on the floor. Resident G indicated she was ambulating by using her IV pole to assist herself to the bathroom. It indicated the resident was determined to have no injuries at the time of the fall. It indicated when the physician was notified of the fall, on 1-26-25 at 2:16 p.m., he ordered for the resident to be sent to the local emergency room for further evaluation and treatment. The "Post Fall 72-hour Monitoring Report," indicated Resident G refused the initial neurological assessment on 1-26-25 at 2:13 p.m. and was in the hospital for the time periods of 1-26-25 at 2:30 p.m., through [unknown time]. The "Post Fall 72-hour Monitoring Report,"			

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	instructions indicated, "This assessment should be completed at the following intervals for follow up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. Initial assessment (B) [baseline]; followed by q15 min [every 15 minutes] x4 [for first hour post fall], q30 min x2 [for second hour post fall]; every hour x2 [for hours 3 and 4 post-fall]; [then] once per shift for 72 hours [post fall]." Upon Resident G's return to the facility on 1-26-25, the "Post Fall 72-hour Monitoring Report," dated 1-26-25, indicated neurological checks began on 1-27-25 at 8:15 p.m. and was dated to reflect neurological checks, including vital signs, were to be conducted, as evidenced by handwritten dates and times of 1-27-25, 1-28-25, 1-29-25, 1-31-25, 2-2-25, 2-4-25, 2-7-25, 2-10-25 and 2-13-25, at 8:15 p.m., on these dates. The form was incomplete, with documentation of assessments for neurological check, but no assessments for skin assessment, for 1-27-25, 1-28-25 and 1-29-25 at 8:15 p.m. The document failed to reflect neurological assessments each shift from 1-26-25, beginning upon return from the hospital and continuing through 1-29-25 at/around 2:15 p.m. In an interview with the Director of Nursing on 2-21-25 at 1:10 p.m., she indicated the 72 hour post fall report was incomplete. On 2-20-25 at 3:37 p.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for Incidents/Accidents/Falls," and dated 630-23. This policy indicated, "It is the policy of the facility to ensure that any incidents/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention			

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	and their safety is established, a written report will be entered into Risk Management (usually Risk Management section of PCC [an electronic health records system]). The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved. The facility will create a data base related to incidents/accidents as part of the QAPI [quality assurance and performance improvement] process to enable trending and tracking. This information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible...In the case of a fall, the resident will have a head to toe assessment to include a pain assessment and assessment as to any change in the ROM [range of motion/movement] ability/function. Further, residents who have an unwitnessed fall much have neuro checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed (by staff), fall...The occurrence will be documented (usually in the Risk Management section of PCC). The progress note within the resident's medical record is to be included. Documentation in the Medical Record should include the following: Description of the occurrence- to include time and place; Physical and mental status of the resident...Documentation of the physical and mental status of the resident(s) involved will be completed each shift (every 8 hours minimally) over at least the next 72 hours or until the resident(s)'s condition improves. Neuro checks will be completed after any head trauma as well as any unwitnessed fall (even if the resident states they did not hit their head) as per policy. The occurrence is to be communicated shift to shift as part of the report until the resident is stabilized and at least 72 hours post fall..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	02/21/2025

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	On 2-20-25 at 4:05 p.m., the Executive Director provided a copy of an undated procedure entitled, "Accident and Incident: Neurological Checks Guidelines." This procedure indicated, "If a resident is involved in an incident/accident an immediate assessment of the resident is completed by the nurse...If a resident has an unwitnessed fall and is unable to express that their head was not impacted during the fall or the fall was witnessed and it can be verified that the resident did hit their head, neurological checks will be completed at intervals to ensure that a head injury has not occurred. Neurological checks consist of the obtain [sic] of vital signs, pupillary [eye] responses, orientation status, skin check, and range of motion ability. The intervals after a suspected head injury from a fall to complete neurological checks are as follows: Every 15 minutes x4 to equal 1 hour; Every 30 minutes x2 to equal 1 hour; Every 1-hour x2 to equal 2 hours; Once per shift x 72 hours. At any point during the neurological assessment time frame, if the resident presents with cognitive or neurological changes, appropriate individuals should be notified." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to ensure residents who admitted to the facility had their orders transcribed correctly into the electronic health record (EHR) that resulted in medication errors for 1 of 3 residents reviewed for medication administration. (Resident D)	F 0760	Past non-compliance: no plan of correction required	03/14/2025

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	This deficient practice was corrected on 2/12/25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policy and procedure regarding transcribing physician orders and the admission process, reviewed all newly admitted residents to identity potential residents, and ongoing review of newly admitted residents during the morning clinical meetings have been completed and documented with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: The clinical record for Resident D was reviewed on 2/20/25 at 2:10 p.m. The diagnoses included, but were not limited to, weakness, cognitive communication deficit, and Parkinson's disease. Resident D was admitted to the facility on 2/3/25. The hospital discharge instructions, dated 2/3/25, indication the instructions to take Sinemet (carbidopa-levodopa) (medication used to treat Parkinson's disease) 25 mg - 100 mg (milligrams); two tablets four times a day. A physician order, dated 2/3/25, indicated the use of Sinemet 25-100 milligrams (mg), one tablet, four times a day for Parkinson's disease. The order did not match the discharge order from the hospital. The medication administration record (MAR), dated February 2025, indicated Sinemet 25-100 mg, one tablet, was administered on 2/4/25 for three administrations and 2/5/25 for two administrations.			

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	An interview conducted with the Director of Nursing (DON), on 2/20/25 at 3:45 p.m., indicated the following day, after a new admission arrived at the facility, she reviews the discharge orders and double checks them compared to what was entered into the electronic health record (EHR) for accuracy. There should be two nurses to double check and sign off on the review of the physician orders for newly admitted residents. An interview conducted with the Nurse Practitioner (NP), on 2/20/25 at 4:18 p.m., indicated there had been a concern regarding errors with transcribing orders from the hospital discharge instructions into the EHR. The NP reviews newly admitted residents and reviews their discharge orders from the hospital and compares such to the EHR. Resident D was a concern she noticed when the order for Sinemet was initially inputted for one tablet four times a day instead of two tablets four times a day as noted on the hospital discharge instructions. This citation is related to Complaint IN00453443. 3.1-48(c)(2)			