STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00433839 and IN00434161. Complaint IN00433839 - No deficiencies related to the allegations are cited. Complaint IN00434161 - No deficiencies related to the allegations are cited. Survey dates: May 28, 29, 30, 31 and June 3, 2024 Facility number: 00537 Provider number: 155409 AIM number: 100267270 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 6 Medicaid: 52 Other: 14 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 4, 2024.	F 0000	June 21, 2024 Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey on June 3, 2024. Please accept this plan of correction as the provider's credible allegation of compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Fields		06/21/2024

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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	that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self-medication administration assessment was completed for residents with medications left at bedside for 1 of 1 random observations. (Resident 125) Finding includes: During a tour on 5/28/24 at 8:59 a.m., observed Resident 125's room, no staff were observed to be in the room or in hallway. Resident 125 was up in a wheelchair and on top of the bedside table one clear plastic cup filled with six tablets, one capsule, and one gelcap was observed. On 5/29/24 9:30 a.m., Resident 125's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, alcohol dependence, and anxiety. Resident 125's clinical record lacked a Self-Medication Administration Assessment. During an interview on 5/29/24 at 9:05 a.m., RN 2 indicated medication should not be left unattended in resident rooms. During an interview on 5/31/24 at 8:37 a.m., the Director of Nursing indicated that no medications are to be left in a resident's room. On 5/29/24 at 12:58 p.m., the Director of Nursing provided a policy titled Medication Administration, dated October 2021. A review of the policy indicated, remain with the resident to ensure that the medication is swallowed. The	F 0554	It is the intent of this facility to ensure residents have a self-administration assessment completed when resident chooses to self-administer their medications. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #125's room was checked on 05.29.24 and no medications remained in the room. Resident was interviewed, BIMs 13, and stated that she does not wish to self-administer her medication. Assessment was completed 05.29.24. RN #2 was re-educated on the policy for Medication Administration 05.29.24 by the Director of Nursing (DON). 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 rooms were audited for medications and no other medications were found on 05.29.24. An audit will be completed by the DON/ADON for residents that choose to self-administer medications and a Self-Administration Assessment was completed as indicated. What measures will be put into	07/05/2024

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	DON indicated that policy provided was currently being followed by facility. 3.1-11(a)		place and what systemic changes will be made to ensure that the deficient practice does not recur: The Director of Nursing (DON) completed an inservice on 06.19.24 with nurses and qualified medication assistants. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. Residents who desire to self-administer medication will have a Self-Administration Assessment completed, physician order obtained as appropriate for self-administration. How the corrective actions will be monitored to ensure the deficient practice will not recur: The DON/Designee will audit 10 random residents for self-administering of medications weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliant after 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 needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator/Designee weekly until resolved.	

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F 0926 SS=D Bldg. 00	483.90(i)(5) Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. Based on interview and record review, the facility failed to perform safe smoking assessments per facility policy for 1 of 5 residents reviewed for safe smoking. (Resident 1) Findings include: On 5/28/24 at 1:15 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves causing muscle weakness and problems with coordination), muscle wasting and atrophy, flaccid hemiplegia (paralysis on one side of the body) affecting right dominant side, and unsteadiness on feet. A Quarterly MDS (Minimum Data Set) assessment, dated 3/21/24, indicated Resident 1 had moderate cognitive impairment. The Care Plan included, but was not limited to: Resident 1 is a supervised smoker as evidenced by current smoking assessment and must be supervised during smoking activity, initiated on 8/7/18. The most recent Smoking Risk Assessment in	F 0926	It is the intent of this facility to ensure a smoking assessment per the facility policy. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 had Smoking Evaluation completed on 06.06.2024, by the Activities Director (AD). 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 who desire to smoke have the potential to be affected by alleged deficient practice. Residents who desire to smoke have been assessed and all Smoking Evaluations are current. The DON audited residents for a Smoking Evaluation on 06.06.24 and assessments were completed as indicated. What measures will be put into place and what systemic changes will be made to ensure that the	07/05/2024

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	Resident 1's clinical record had an effective date of 9/19/22 and indicated the following for Resident 1: - required the use of a protective apron for smoking breaks. - had a moderate problem with general awareness and orientation, including the ability to understand the facility safe smoking policy. - had a moderate problem with injury potential for causing injury to self or others relating to smoking materials and a moderate problem with history of hazardous behavior related to smoking materials. During an interview on 5/30/24 at 2:25 p.m., the DON (Director of Nursing) indicated that Resident 1 should have had smoking assessments done both quarterly and annually. On 5/29/24 at 12:55 p.m., the DON provided an undated policy titled "Smoking Policy", and indicated it was the current policy in use by the facility. A review of the policy indicated under Procedure section 6. "Residents will be assessed for safe smoking behavior prior to smoking at the facility. This assessment is found on PCC [Point Click Care]. The resident will be further assessed for smoking, quarterly, annually, after an "unsafe" smoking episode and after a change of condition."		deficient practice does not recur: Activity Director (AD) or designee completes the Smoking Evaluation for residents who desire to smoke at admission/readmission, change of condition and quarterly. The DON/Designee in-serviced the staff on the Smoking Policy and completing the Smoking Evaluation upon admission, quarterly and change in condition or new desire to smoke. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur: The AD/Designee will audit 5 random residents who desire to smoke weekly x 4 weeks, then 3 residents who desire to smoke weekly x 4 weeks, then 2 residents who desire to smoke monthly x 4 months for Smoking Evaluation. If the facility is within 95% compliant after 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. 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	

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			Administrator or designee weekly until resolved.	