STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

(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. Survey dates: January 31, 2023 and February 1, 2, 3 and 6, 2023 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Census Bed Type: SNF/NF: 11 SNF: 82 Total: 93 Census Payor Type: Medicare: 14 Medicaid: 49 Other: 30 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/13/23.	F 0000	This Plan of Correction shall serve as this facility's Credible Allegation of Compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified in the survey. We respectfully request a paper review for compliance.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed in the required time frame for 2 of 2 residents reviewed.	F 0638	This Plan of Correction shall serve as this facility's Credible Allegation of Compliance. Preparation, submission and	02/25/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Schmidt	Administrator	02/24/2023

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	(Residents 14 & 30) Findings include: 1.A review of Resident 14's clinical record was completed on 2/3/2023 at 11:08 A.M. The record indicated a Quarterly MDS assessment was submitted on 1/23/2023. The assessment reference date was 1/11/2023. The previous Quarterly MDS was submitted on 10/6/2022. The assessment reference date was 9/22/2022. 2. A record review of Resident 30's clinical record was completed on 2/3/2023 at 11:10 A.M. The record indicated an Annual MDS assessment was submitted on 1/25/2023. The assessment reference date was 1/12/2023. The previous quarterly MDS was submitted on 10/7/2022. The assessment reference date was 9/23/2022. During an interview on 2/6/2023 at 10:16 A.M., the MDS Coordinator indicated quarterly MDS assessments were to be completed every 92 days from the last assessment. She indicated the auditing entity considered a delinquent record to be greater than 110 days between assessments and the facility considered this timeframe as the correct frame. On 2/6/2023 at 11:38 A.M., the MDS Coordinator provided documentation from the auditing entity, titled, "Supportive Documentation Requirements User Guide". She indicated the record considered a delinquent record greater than 113 days during their case mix review. On 2/6/2023 at 3:33 P.M., the Director of Nursing indicated a policy was not available for MDS assessments. She stated the facility follows the RAI (Resident Assessment Instrument) User's		implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing paper submission of audits and education as evidence of compliance with the state and federal requirements identified in the survey. We respectfully request a paper review for compliance. **F638:** It is the practice of the Waters of Wakarusa to follow the guidelines of the RAI manual for MDS scheduling and timely completion of the MDS. Resident 14: MDS are currently in compliance Resident 30: MDS are currently in compliance The facility audited all of the facility MDS, to assure compliance and within the correct timeframes. All MDS are currently in compliance, this audit was completed on 2-17-23. The facility has also audited the entire MDS schedule on PCC to ensure the	

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	Manual for MDS assessments. The RAI Manual indicated, " ...The ARD [assessment reference date] of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 92 days after the ARD of the most recent OBRA [Omnibus Budget Reconciliation Act] assessment ...." 3.1-31(d)(3)		assessments are completed timely and that the resident MDS's are completed timely. Administrator and Corporate MDS Director provided an in-service education on 2-22-2023 with MDS Coordinators on the scheduling and timely completion of the MDS, following the RAI manual – See Attach F638 – A. The MDS/Designee will complete the QA audit tool when auditing for compliance, see Attach F638- B. The MDS will audit the PCC schedule 1x a week for a minimum of 3 months, and then monthly for the next 3 months to ensure the MDS are scheduling according to RAI guidelines. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. MDS Coordinator is responsible for compliance. DON is responsible for overall compliance. All systematic changes will be in compliance by 2-25-23	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to develop person-centered care plans for 4 of 28 residents whose care plans were reviewed (Residents 40, 60, 87, and 37.) Findings include: 1. During an observation, on 1/31/2023 at 2:51 P.M., Resident 40's feet and lower legs were very swollen. A clinical record review was completed, on 2/02/2023 at 1:48 P.M., and indicated Resident 40's diagnoses included, but were not limited to, chronic systolic congestive heart failure and chronic diastolic congestive heart failure. Physician orders for Resident 40 included, but were not limited to, 1500 cc (cubic centimeters) fluid restriction for 24 hours divided with dietary, 860 cc day shift, 500 cc evening shift, and 140 night shift. Diet order was 2 gm (grams) sodium. Medication orders included, but were not limited to, Torsemide 20 mg (milligrams.) The care plan for Resident 40 included, but was not limited to, for nutritional risk with an intervention in that indicated 2 gm sodium mechanical soft diet, 1500 ml fluid restriction. An intervention that indicated how the fluid restriction was divided between nursing and dietary could not be found. During an interview on 2/06/2023 at 10:01 A.M., the Dietary Manager indicated Resident 40's care plan should have been person-centered and	F 0656	**F656:** It is the policy of Waters of Wakarusa to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental, and psychosocial needs that have been identified by the comprehensive assessment. Resident 40: HCP was reviewed and updated by 2-6-23 to address the fluid restriction intervention; NP also consulted. Resident 60: HCP was reviewed and updated by 2-6-23 to address the depression concern to be a more patient centered careplan. Resident 87: HCP was reviewed and updated by 2-6-23 with appropriate CPAP MD orders and for the careplan to be more patient centered. Resident 37: HCP was reviewed and updated by 2-6-23 to address more specifically, and with a more patient centered careplans to address the behavior careplan. Facility audited all resident careplans to ensure they were in compliance as person centered careplans, by 2-22-23. The DON completed the In-service education with all licensed nurses	02/25/2023

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	indicated fluid amounts for nursing and dietary but did not. 2. A clinical record review was completed, on 2/02/2023 at 9:20 A.M., and indicated Resident 60's diagnoses included, but were not limited to, major depressive disorder. A Quarterly MDS (Minimum Data Set) Assessment, dated 1/19/2023, for Resident 60 indicated she was tired with low energy 2 out of 6 days and fidgeting 7 out of 11 days. The resident did not have a current order for an antidepressant. A care plan for Resident 60 had a problem, dated 10/30/2019, indicated a problem of depression with interventions that included, but were not limited to, notify physician as needed, encourage resident to attend activities and praise efforts, and provide support and encouragement as needed. During an interview on, 2/3/2023 at 3:38 P.M., the social service staff member indicated that Resident 60's care plan was not person-centered for depression and should have been. 3. During an observation of Resident 87's room, on 2/1/2023 at 1:57 P.M., a CPAP (continuous positive airway pressure) machine was noted at his bedside. A clinical record review was completed, on 2/2/2023 at 11:14 A.M., and indicated Resident 87's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and obstructive sleep apnea. Physician orders, dated 11/13/2022, for Resident		and department heads by 2-22-23. Attachment 656-A. Charge nurses will be responsible to update plan of care at time of discovery of any new behaviors, depression concerns, MD orders and ensure that plan of care be more patient centered including the appropriate interventions, objectives, time frames, etc. Charge nurses will be instructed to document any new behaviors, depression concerns, clarification of MD orders on the 24hour report sheet. The nurse managers review the EMR, 24hour report sheet on a routine basis to ensure that resident HCP's are revised/developed to be more patient centered careplans. The DON/Designee will complete the QA tool "24 Hour Condition Report Review" daily x5days for 10 residents for 1 week: then bi-weekly for 6 weeks for 10 residents and then monthly for 10 residents for a minimum of 6 months. See Attach F656-B. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. UM will monitor for compliance. DON is responsible for overall compliance.	

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	87 included, but were not limited to, CPAP to wear at night and for naps. Resident 87's care plan included, but was not limited to, a problem that indicated a risk for altered sleep and respiratory function related to sleep apnea. Interventions included, but were not limited to, apply CPAP as ordered, monitor during sleep for signs and symptoms of apnea, and notify physician of any difficulties. During an interview, on 2/06/2023 at 10:12 A.M., the unit manager indicated the care plan for Resident 87 was not person-centered and should have been. 4. A clinical record review was completed on 2/02/2023 at 11:07 A.M. Resident 37's diagnoses included, but were not limited to, heart failure, chronic kidney disease, anxiety, depression, Psychotic disorder, and dementia. A Significant change MDS (Minimum Data Set) Assessment, dated 12/25/2022, indicated Resident 37 had physical behaviors on 4-6 days, verbal behaviors on 4-6 days and other behaviors 4-6 days during the assessment period. Current physician orders, dated 1/4/2023, indicated Resident 37 was to receive Seroquel (antipsychotic) 25 mg (milligrams) three times a day for psychotic disorder. A current care plan, dated 1/17/2023, indicated: Behavior: The resident displays mood issues as exhibited by restlessness, increase agitation and yelling out. Interventions included, but were not limited to: consult with [name of hospice] as needed, wheel the resident around facility which can become a distraction for her. Administer psych medication as ordered. Monitor medication side effects at least daily on psychotropic		All systematic changes will be completed by 2-25-2023	

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	medication record. Provide support and encouragement PRN (as needed). Provide education and support to family. A care plan, dated 7/6/2022, for Anxiety indicated: the resident often expresses/or exhibit restlessness, nervousness. Intervention included to administer antipsychotic for anxiety/mood as ordered. During an interview, on 2/6/2023 at 2:05 P.M., the Director of Nursing indicated the care plans were not person centered and should be. On 2/6/20223 at 3:34 P.M., the Director of Nursing provided the policy titled, "Baseline Care Plan Assessment/Comprehensive Care Plan", last updated 9/18/2018, and indicated the policy was the one currently used by thee facility. The policy indicated"...The Baseline Care Plan will be discontinued upon the completion of the Comprehensive Care Plan. The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the "Person-Centered" Plan of Care approach for each resident that includes measurable objectives's and timetables to meet the resident's medical. nursing, physical functioning, mental and psychosocial needs. 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that			

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	includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observations, interviews, and clinical record review the facility failed to revise a care plan following a fall for 1 out of 28 care plans that were reviewed (Resident 40.) Finding includes: During an interview with Resident 40, on 1/31/2023 at 2:53 P.M., she indicated she fell the day before Thanksgiving and fractured her wrist. A clinical record review, on 2/02/2023 at 1:48 P.M., indicated diagnoses for Resident 40 included, but were not limited to, unspecified fracture of left wrist and hand. Resident 40's Quarterly MDS (Minimum Data Set)	F 0657	**F657:** It is the policy of the Waters of Wakarusa to update resident's plan of care with an intervention following a fall to prevent reoccurrence, while being a patient centered careplan. Resident 40: HCP was reviewed and updated by 2-6-23 to update the careplan to include the appropriate fall prevention interventions. All Residents HCP has been reviewed by the IDT to ensure current interventions are in place. The HCP will be reviewed and updated promptly with appropriate	02/25/2023

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	Assessment, dated 12/19/2022, indicated she required extensive assist of 1 staff person for bed mobility, transfers, dressing, and toileting; Occupational Therapy for 202 minutes over 5 days; and no restraints or alarms. The MDS also indicated no falls as the fall was noted on a Significant Change MDS, dated 12/2/2022. The care plan for Resident 40 included, but was not limited to, a problem dated 6/30/2017, that indicated a fall risk. Interventions included, but were not limited to, call light in reach, and reinforce need to call for assistance. Interventions added after fall included, but were not limited to, therapy to screen, dated 11/25/2023; gait belt to be used for all transfers, dated 11/26/2022; monitor for pain each shift, administer pain medication if needed, dated 11/26/2022. No new interventions were noted to prevent further falls. During an interview on 2/6/2023 at 10:15 A.M., the unit manager indicated that Resident 40's care plan was not updated to prevent further falls and should have been. A policy provided by the DON (Director of Nursing) on 2/7/2023 at 2:34 P.M. titled, "Baseline Care Plan Assessment/Comprehensive Care Plans", revised 9/18/2018, indicated " ...the comprehensive care plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ...." 3.1-35(d)(2)(B)		interventions following any future falls or changes in condition. The nurse management team will complete an audit of all resident falls by 2-25-23, to assure the HCP have been updated per policy with appropriate interventions. The DON completed an all-licensed nurse in-service by 2-22-23 to review care planning with fall interventions. See Attach F656-A. The nurse managers review the 24hour report sheet 5x/week to ensure that resident falls are careplanned appropriately with appropriate interventions. The DON/Designee will complete the QA tool “24 Hour Condition Report Review” daily x5days for 1 week for 10 residents: then bi-weekly for 6 weeks for 10 residents and then monthly for 10 residents for a minimum of 6 months. See attach F657-B. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. UM will monitor for compliance. DON is responsible for overall compliance. All systematic changes will be completed by 2-25-23.	

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F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			

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	Based on record review and interview, the facility failed to provide a restorative therapy program for 2 of 2 residents reviewed for rehabilitation. (Resident 35) Finding includes: A clinical record review of Resident 35 was completed on 2/2/2023 at 9:37 A.M. Diagnoses included, but were not limited to, diabetes mellitus, heart failure, anxiety, and depression. A Quarterly Minimum Data Set (MDS) Assessment in 12/30/2022 indicated Resident 35 had therapy services of physical therapy 10/20/2022-11/3/2022 and occupational therapy 10/20/2022-11/3/2022. He required extensive assistance with one staff member for bed mobility and toileting, and extensive assistance with two or more staff members for transfers. The MDS indicated he had no cognitive impairment. During an interview with Resident 35 on 1/31/2023 at 2:29 P.M., he indicated he wanted therapy services for strengthening so he could walk again. He indicated the facility was aware of his request. A Care Plan initiated on 6/17/2020, and updated on 7/9/2021, indicated, " ...I need assist with all ADL's [activities of daily living] due to respiratory failure and hypoxemia. I need limited assistance with eating/drinking, extensive assistance with bed mobility, transfers and toileting, need for assistance with personal care ...." On 2/6/2023 at 10:34 A.M., a review of the Occupational Therapy Discharge Summary was completed. The summary indicated, a restorative nursing program was to be in place after discharge from therapy service to facilitate the current level	F 0676	**F676:** It is the policy of the Waters of Wakarusa to provide the necessary care and services (restorative nursing program) to ensure that a resident's ability in ADL's do not diminish unless there are unavoidable circumstances. Resident 35: Restorative program was initiated for resident based on resident ability. Facility audited all residents to ensure appropriate programs (restorative programs) were in place for all resident who remain in facility following the completion of therapy services. Administrator provided in-service education to the therapy staff and MDS staff on the Policy and Procedure for the facility restorative nursing programs and the communication form/tool, 2-22-23; Attach F676 – A. The MDS/Designee will complete the QA MDS audit tool weekly for 1 month, and then monthly for a minimum of 5 months. See Attach F676-B. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. MDS Coordinator is responsible	02/25/2023

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	155582	A. BUILDING 00 B. WING	02/06/2023

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	of performance and to prevent decline. The summary indicated instructions had been completed for the restorative nursing program and shared with the interdisciplinary team. The program included active range of motion, bed mobility, and transfers. During an interview on 2/6/2023 at 10:37 A.M., certified occupational therapist assistant 2 indicated the occupational therapy discharge summary included a restorative nursing program. On 2/6/2023 at 11:58 A.M., the MDS Coordinator indicated Resident 35 was missed being placed on the restorative program during the facility's transition of ownership. On 2/6/2023 at 2:24 P.M., the MDS Coordinator provided a form titled, "Therapy Communicator". The form indicated wheelchair transfers with staff assistance of stand-by assistance/supervision with a gait belt effective on 11/2/2022. The form indicated to encourage exercise program in the resident's room with 4-pound weights. The MDS Coordinator indicated she never received the therapy communication for the restorative nursing program. On 2/6/2023 at 3:33 P.M., the Director of Nursing provided the policy, "Policy and Procedure for facility Restorative Nursing Programming". The policy indicated, " ...The facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome. The facility is responsible to ensure that residents receive care and services needed if they are unable to perform their own ADL care independently. The facility must also		for compliance. DON is responsible for overall compliance. All systematic changes will be in compliancy by 2-25-23	

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	ensure the resident reaches and maintains his or her highest level of Range of Motion and to prevent avoidable decline in Range of Motion ...." 3.1-38(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide individualized activities for a severely cognitively impaired resident for 1 of 3 residents reviewed for activities. (Resident 33) Finding includes: On 1/31/2023 at 11:38 A.M. and on 2/3/2023 at 1:24 P.M., Resident 33 was observed sleeping in her recliner. A clinical record review was completed on 2/3/2023 at 1:33 P.M. Diagnoses included, but were not limited to, dementia, anxiety, depression, and seizures. A Quarterly Minimum Data Set (MDS) Assessment on 1/19/2023 indicated Resident 33 was not able to be interviewed for her cognitive	F 0679	**F679:** Activities It is the policy of Waters of Wakarusa to provide an ongoing activities program to residents in their choice of activities, both group and individualized 1 on 1 activities, based on a comprehensive assessment, careplan and preferences of each resident; designed to meet the interests of and support each residents' physical, mental, and psychosocial needs. Resident 33 was not negatively affected by this deficient practice. This resident was involved with activities daily and was receiving individualized 1 on 1 activities, daily, per observations and	02/25/2023

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	function. She required extensive assistance with one staff member for transfers. She was able to make herself understood and understands others. She had moderate difficulty hearing others and did not wear a hearing aide. She had adequate vision. She had behaviors that included wandering for 4-6 days of the 14-day look back period. An Annual MDS Assessment on 10/20/2022, indicated it was somewhat important to do her favorite activities and to get fresh air when the weather is good. A Care Plan, updated on 1/18/2023, indicated, " ...The resident is functioning at a cognitively impaired level related to: A diagnoses of dementia or other severe neurological impairment., Observable loss of memory., Symptoms & Problems are manifested by: Disorientation to:, person, place and time, Symptoms & Problems are manifested by: Inability to initiate social contact ...." Resident 33's goals included: The resident will engage in a sensory exercise 2-3 times per week, the resident will demonstrate enhanced awareness by engaging in a tactile exercise, and the resident will demonstrate enhanced awareness by engaging in a taste exercise. Resident 33's care plan interventions included: to provide individual focused (1 on 1) sessions 2-3 times per week emphasizing sensory and environmental awareness, integration, and stimulation, to use a wide variety of sensory stimulation props to reach and connect with Resident 33, and to emphasize increased social integration and reminiscing to utilize her strengths. An Activity Progress Note on 1/18/2023, indicated, " ...Resident responded to short visits, sensory activities such as Memory Boxes, hand care including use of hand lotion ... The positive		interviews with staff; however, activity staff had not consistently documented that this care has been provided. The Activity Director will complete an audit of all resident's activity careplans and documented participation in activities, focused on 1 on 1 activity needs by 2-25-23. Staff have been in serviced on the activity policy, expectations of resident interaction and participation based on their individual assessments and following careplans, expectations of documenting the services and activities provided to residents that require 1 on 1 individualized activity. Staff have been in serviced on 2-7-23, 2-13-23, 2-22-23. See attach F679-AActivity Director will review the 24-hour report daily, focused on resident declines and needs of additional 1 on 1 activities, keep an updated list of all residents requiring 1 on 1 individualized activity, and will monitor daily. The Activity Director/Designee will complete the QA tool "1 on 1 activities Review" daily x5 days for 1 week for 10 residents; then bi-weekly for 6 weeks for 10 residents and then monthly for 10 residents for a minimum of 6 months. See Attach F679-B. Any identified issues will be corrected upon discovery and logged on the facility QA tracking	

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	is that staff will be with her 1:1 [one on one]. What they can do is limited, but they do try to talk to resident, read her mail. Due to her sight and hearing decline, resident is unable to benefit from most of the Memory Boxes, however staff will use hand lotion on her as well as trying to use different fabrics for touch. Resident will accept lotion, but does not care for any other sensory activity as it appears to irritate her. Resident does enjoy wheeling herself around facility. Staff will continue to provide 1:1's 3-4x [3 to 4 times] weekly ...." The Activity Log in the electronic medical record indicated Resident 33 had the following activities: 1/6/2033 conversation/social 1/13/2023 audio/visual activity, and a self-directed activity. 1/18/2023 audio/visual activity and a group activity. 2/1/2023 1:1 provided by another person 2/4/2023 1:1 by staff During an interview on 2/6/2023 at 11:00 A.M, the Activity Director indicated the staff are not documenting the one-on-one visits. She indicated that daily census sheets are also used to document activity attendance. She was able to provide documentation of the following activities, in addition to the electronically documented activities: 1/2/2023 sensory activity 2/1/2023 family visit and sensory activity 2/4/2023 family visit The Activity director indicated the staff was documenting in the electronic health record and placing the census sheets in the file. The Activity director indicated Resident 33 was meeting her care plan goals, but the staff could be doing better.		log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. Activity Director will be responsible for compliance. Administrator will monitor for overall compliance. All systematic changes will be completed by 2-25-2023	

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	On 2/6/2023 at 11:13 A.M., the Activity Assistant 4 indicated the family visits at least once or twice a week, and the department is lacking the documentation of these visits. She indicated Resident 33 is difficult to deal with as she will yell at the staff and will wander the hallways. She indicated Resident 33 cannot hear or see. On 2/6/2023 at 3:33 P.M., the Director of Nursing provided the policy titled, "Activities Program". The policy indicated, " ...It is the policy of the facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents ...5) Facility will provide 1:1 program for residents who are unable or who desire not to attend or join group activities ...7) Facility will develop specialized activities for residents with Alzheimer's Disease and/or other Dementia related conditions ...12) The Activity Director will ensure that timely, organized records are kept to show the participation/attendance of residents in both individual and group activities ...." 3.1-33(b)(8)			
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,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observations, interviews, and clinical record review, the facility failed to obtain orders for respiratory care for 1 out of 3 residents reviewed (Resident 87) During an observation and interview with Resident 87, on 2/1/2023 at 1:57 P.M., a CPAP (continuous positive airway pressure) machine was noted on the nightstand. Resident 87 indicated he had been using the CPAP machine for awhile now but could not recall exactly how long. A clinical record review was completed, on 2/3/2023 at 11:14 A.M., indicated diagnoses for Resident 87 included, but were not limited to, chronic obstructive pulmonary disease and obstructive sleep apnea. The Quarterly MDS (Minimum Data Set) Assessment, dated 11/12/2022, indicated Resident 87 had a BIMS (Brief Interview for Mental Status) score of 13, which indicated intact cognition; and trouble breathing. Resident 87's physician orders included, but were not limited to, head of bed elevated while in bed at all times, dated 11/5/2022 and wear CPAP at bedtime and for naps, dated 11/13/2022. No other orders for the CPAP could be found. The care plan problems for Resident 87 included, but were not limited to, risk for altered sleep and respiratory function related to obstructive sleep apnea, dated 12/19/2022. Interventions included, but were not limited to, apply CPAP as ordered, elevate head of bed, monitor during sleep for signs and symptoms of apnea, and notify	F 0695	**F695:** It is the policy of the Waters of Wakarusa to provide residents who need respiratory care, noninvasive breathing support consistent with professional standards as well as the person centered careplan. Resident 87: The specific settings and schedule for the CPAP were corrected by 2-4-23 and a person centered careplan was developed with the specific MD orders. Facility audited all resident careplans to ensure they were in compliance as person centered careplans for respiratory care, by 2-22-23. DON provided in-service education to all-licensed nurse in-service by 2-22-23, see attach F656-A, F695-C. The nurse managers review the 24hour report sheet 5x a week to ensure that resident falls are careplanned appropriately with appropriate interventions. The DON/Designee will complete the QA tool “24 Hour Condition Report Review” daily x5days for 1 week for 10 residents, then bi-weekly for 6 weeks for 10 residents and then monthly for 10 residents for a minimum of 6 months. See attach F695-B. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI	02/25/2023

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	physician of any difficulties. During an interview, on 2/6/2023 at 10:12 A.M., the unit manager indicated that Resident 87 had no further orders for the CPAP and there should have been orders to include, but not limited to, changing the tubing, filters, cleaning the machine, and amount of distilled water. A policy provided by the DON (Director of Nursing) on 2/7/2023 at 2:34 P.M. titled, "Continuous Positive Airway Pressure" indicated, " ...CPAP therapy must have a written physician's order. The order must include the level of CPAP, FIO2 [fraction of inspired oxygen] if needed, and humidifier if needed ...." 3.1-47(a)(6)		monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. UM will monitor for compliance. DON is responsible for overall compliance. All systematic changes will be completed by 2-25-23.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review, observation and interview, the facility failed to ensure side effects were monitored, behaviors were documented, new behavior assessments and follow up assessments were completed for 1 of 5 residents reviewed for unnecessary medications. (Resident 37) Finding includes: A clinical record review was completed on, 2/02/2023 at 11:07 A.M. Resident 37's diagnoses	F 0758	**F758:** It is the policy of the Waters of Wakarusa to provide appropriate medications for appropriate diagnosis, behavioral issues, and a variety of clinical issues; also, to include the appropriate supporting information/documentation to make the best-informed decision when communicating with the medical professionals as they	02/25/2023

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	included, but were not limited to: heart failure, chronic kidney disease, fibromyalgia, depression, anxiety, psychotic disorder and dementia. A Significant Change MDS (Minimum Data Set) Assessment, dated 12/25/2022, indicated the resident had severe cognitive impairment, had physical behaviors on 4-6 days, verbal behaviors on 4-6 days and other behaviors on 4-6 days out of 7 days. Received antidepressant and antianxiety medications. Resident 37's current physician orders for February included: Seroquel (antipshychotic) 25 mg (milligram) 1 tablet by mouth three times a day for psychotic disorder. Bupropion (antidepressant) 100 mg 2 tablets daily for depression. Hydroxyzine (antihistamine) 50 mg 1 tablet every 6 hours as needed for anxiety. Remeron (antidepressant) 15 mg 1 tablet every night for anxiety. Dilaudid (opioid) 2 mg take 1 mg by mouth every 4 hours as needed for pain. A current care plan, dated 1/17/2023, indicated Resident 37 had behaviors: the resident displays mood issues as exhibited by: restlessness, increase agitation and yelling out. Interventions included, but were not limited to: consult with hospice as needed. Wheel the resident around facility which can become a distraction for her. Administer psychotropic medication as ordered. Monitor medication side effects at least daily on psychotropic medication record. Provide support and encouragement as needed. Provide education and support to family. A current care plan, dated 7/6/2022 , indicated Resident 37 had anxiety: often expresses/or exhibit restlessness, nervousness. Interventions included but were not limited to: Administer antipsychotic		decide on any medications changes for behavior management. Resident 37: In working with the nursing staff and medical professionals; and continued observations of Resident 37, the facility obtained the additional supportive documentation to support the increase in the medication. The resident has responded in a positive manner. The nurse management team will complete an audit of all resident careplans focused on behaviors, GDR, the appropriate supportive documentation when seeking to utilize medications for behavior management and being person centered careplans by 2-25-23; to ensure all careplans are person centered and have the supportive documentation when selecting the most appropriate intervention. The DON provided in-service education to all-licensed nurses by 2-22-23, see attach F656-A. The nurse managers review the 24hour report sheet 5x week to ensure that resident falls are careplanned appropriately with appropriate interventions. The DON/Designee will complete the QA tool “24 Hour Condition Report Review” daily x5days for 1 week for 10 residents; then bi-weekly for 6 weeks for 10 residents and then monthly for 10 residents for a minimum of 6 months. See attach, F758-B.	

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	medication for anxiety/mood as ordered. A current care plan, dated 7/6/2022, indicated Resident 37 had the potential for signs and symptoms of depression of persistent feelings of sadness loss of interest, changes in sleep, appetite, energy related to decline in health. Interventions included, but were not limited to: give antidepressant medications as ordered, monitor side effects at least daily, discuss feelings about placement, encourage resident to attend activities, provide support and encouragement as needed and listen attentively and follow up on issues as needed. A MAR (Medication Administration Record) dated December 2022, indicated the resident had received Seroquel on 12/30/2022 an 12/31/2022. An order, dated 12/30/2022, indicated to monitor for side effects of the Seroquel every day shift. Resident 37 had also received bupropion from 12/28/2022 through 12/31/2022. An order, dated 12/7/2022, indicated to monitor for side effects of bupropion every day shift. A Social Service Note, dated 12/29/2022 at 11:00 A.M., indicated Resident 37 had yelled out saying "help me", "hello", and other statements. Social service staff sat with the resident and provided 1 on 1. The resident stated she was afraid to die. Social Service staff informed hospice to see if chaplain could provide support to resident. The MAR for January 2023, indicated Resident 37 had received Seroquel three times a day from January 4th through January 31, 2023. The MAR lacked any documentation to show the side effects were being monitored for the psychotropic medication.		Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. UM will monitor for compliance. DON is responsible for overall compliance. All systematic changes will be completed by 2-25-23.	

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	The MAR for January 2023, indicated Resident 37 had received hydroxyzine 4 times from January 5th, through January 10 10th. An order, dated 1/24/2023 indicated to monitor side effects every day shift on the hydroxyzine. A Social Service Note, dated 1/3/2023 at 11:27 A.M., indicated she had spent time with the resident wheeling her around the facility. A Nursing Progress Note, dated 1/3/2023 at 1:41 P.M., indicated the resident was very agitated that started at 12:45 P.M. Yelling profanities, hitting and kicking at staff. Refused 2 PM medications as well as as needed medications. Multiple attempts to redirect, placed resident in recliner, offered snacks. New order received on 1/3/2023 at 5:15 P.M. to increase the Seroquel to three times a day. An emar Medication Administration Note, dated 1/10/2023 at 8:19 P.M., indicated: hydroxyzine give 1 tablet by mouth every 6 hours as needed for agitation and restlessness. Yelling, climbing out of bed. A Physician's order, dated 1/9/2023, on the January MAR indicated Behavior Monitoring & Interventions: excessive worrying and restlessness and yelling out every shift with a start date of 1/9/2023. Yes was documented on 1/9, 1/10, 1/12, 1/15, 1/16 and 1/21/2023. The record lacked the documentation of what behaviors occurred and or the interventions tried to decrease the behaviors. An emar Medication Administration Note, dated 1/9/2023 at 8:49 P.M., indicated: was a behavior observed? Yes. No other documentation of what			

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	155582	A. BUILDING 00 B. WING	02/06/2023

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	behavior occurred or what interventions were implemented. An emar Medication Administration Note, dated 1/12/2023 at 8:03 P.M., indicated: was a behavior observed? Yes. No other documentation of what behavior occurred or what interventions were implemented. An emar Medication Administration Note, dated 1/15/2023 at 4:27 P.M., indicated: was a behavior observed? Yes. No other documentation of what behavior occurred or what interventions were implemented. An emar Medication Administration Note, dated 1/16/2023 at 8:14 P.M., indicated: was a behavior observed? Yes. No other documentation of what behavior occurred or what interventions were implemented. An emar Medication Administration Note, dated 1/31/2023 at 9:38 P.M., indicated: was a behavior observed? Yes. No other documentation of what behavior occurred or what interventions were implemented The MAR for February 2023, indicated Resident 37 had received Seroquel three times a day from February 1st through February 5th. An order, dated 12/30/2022, indicated to monitor for side effects of the Seroquel every day shift. The resident received the PRN (as needed) hydroxyzine 50 mg on 2/3/2023. An order, dated 1/24/2023 indicated to monitor side effects every day shift on the hydroxyzine. Resident 37 had received bupropion twice a day from February 1st through February 5th. An order, dated 1/24/2023, indicated to monitor for side			

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	effects of bupropion every day shift. The MAR for February 2023, indicated Resident 37 received remeron every day from February 1st through February 5th. An order dated 9/13/2022, indicated th monitor for side effects every day shift. An emar Medication Administration Note, dated 2/3/2023 at 10:27 P.M., indicated the resident was calling out for help, stating I need to go home and taking clothes off. An emar Medication Administration Note, indicated the as needed medication hydroxyzine was effective. An emar Medication Administration Note, dated 2/4/2023 at 1:50 P.M., indicated: was a behavior observed? Yes. No other documentation of what behavior occurred or what interventions were implemented. A Behavior Charting Note, dated 2/4/2023 at 1:53 P.M., indicated the resident was yelling out and wanting to get out of her chair, very loud yelling about witches and warlocks and yelling for the police. No documentation of what interventions were tried to decrease the behaviors was documented. A Behavior Charting Note, dated 2/4/2023 at 10:00 P.M., indicated the resident was claiming staff members want to kill her. Redirection and reorientation to reality was documented at the bottom of the page. An emar Medication Administration Note, dated 2/5/2023 at 1:10 P.M., indicated: Was a behavior observed? Yes. A Behavior Charting Note, dated 2/5/2023 at 11:30			

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	A.M., indicated the resident was yelling that someone was robbing her and there was a gun in the closet. Talked with resident and medication taken documented at the bottom of the page. An emar Medication Administration Note, dated 2/5/2023 at 11:43 A.M., indicated the resident was given Dilaudid 1 mg. A Physician's order, dated 1/9/2023, on the February MAR indicated Behavior Monitoring & Interventions: excessive worrying and restlessness and yelling out every shift with a start date of 1/9/2023. Yes: was documented on 2/4 and 2/5/2023. The record lacked the documentation of what behaviors occurred and or the interventions tried to decrease the behaviors. During an interview, on 2/06/2023 at 11:38 A.M., Social Service staff indicated they follow the facilities policy for monitoring side effects. On 2/6/2023 at 11:38 A.M., Social Service staff provided the policy titled," Antipsychotic Medication Review", dated 3/17/2016, and indicated the policy was the one currently used by the facility. The policy indicated"...Review Nursing Notes for documentation of daily side effect monitoring and follow-up to side effects...." During an interview, on 2/6/2023 at 2:05 P.M., the Director of Nursing indicated they have had issues with the charting of behaviors. The nurses were putting yes on the MAR, but it did not mean the resident had had a behavior. The nurses should open up a Behavior Assessment and document in the assessment about the behavior. She indicated they had noted this in January and had provided education on the documentation of behaviors to the Nurses. It happened on 1/18 and			

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	1/20/2023. During an interview, on 2/6/2023 at 3:10 P.M., the Director of Nursing indicated the side effects should be monitored more than daily, the care plans were not person centered for the behaviors, and there were no further assessments after 12/23/2022, and for the other behaviors that had recently occurred. On 2/6/23 at 3:10 pm the DON indicated the side effects should be monitored more than daily. On 2/6/2023 at 2:55 P.M., Social Service staff provided page 4 of a policy titled," Guidelines For Handling And Addressing Behavioral Emergencies", undated, and indicated the facility used these guidelines. The guideline indicated"... 7. Any interventions implemented for behavior control will be monitored by nursing staff and /or SSD daily until the behavior is considered to be managed... 11. Every resident behavior will be assessed and addressed individually. There is no Standing Program for behavior management. C. Documentation: 1. Record specifics related to the behavior incident(s). Include time, place, duration, actions observed by the resident, statements or vocalizations made by the resident, possible causative factors, persons involved other than the resident, witnesses's, behavior intensity, interventions, notifications, orders received and resolutions. This documentation should be done on a behavioral occurrence form fro review at the CQI meeting and/or the Behavior Meetings. 2. Documentation in the clinical record should include facts related to time, possible causative factors, actual behavior with consequences, interventions and outcomes...." On 2/6/2023 at 3:34 P.M., the Director of Nursing provided the policy titled, "Behavior Management			

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	Psychotropic Medication Protocol", undated, and indicated th policy was the one currently used by the facility. The policy indicated"...Residents who receive antipsychotic antidepressant sedative/hypnotic or antianxiety medications are to be maintained at the safest, lowest dosage necessary to manage the resident condition. Residents will be reviewed routinely for the effectiveness and monitored for side effects of these medications. ...2. Established resident with new onset of adverse behaviors: a. The behavior will be documented and communicated to Social Service, and place the resident on the 24 hour report for appropriate documentation/communication. ..c. The Interdisciplinary care team /charge nurse will update the Care Plan to include the problem behavior goals and approaches. d. The nurse will review the other caregivers the behaviors to be monitored. ...3. Establish resident receiving psychotropic/psychoactive medications/behavior management program. ...d. The Interdisciplinary care team will update the Care Plan to include the problem behavior goals and approaches. e. The planned interventions for each individual resident's behavior will be communicated to the appropriate staff member interventions and response will be documented...." 3.1-48(a)(3) 3.1-48(b)(2)			