STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF LEBANON, THE	1585 PERRY WORTH RD LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404340 and IN00406257. Complaint IN00406257 - Federal/state deficiencies related to the allegations are cited at F684 and F919. Complaint IN00404340 - No deficiencies related to the allegations are cited. Survey dates: April 13 and 14, 2023. Facility number: 000118 Provider number: 155211 AIM number: 10029470 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 27 Other: 13 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 27, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion 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. The facility respectfully requests paper compliance for this citation.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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

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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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to provide additional nursing assessments for an unresponsive resident who ended up in the hospital Intensive Care Unit (ICU) for 1 of 1 resident reviewed for nursing assessments (Resident B) Finding include: On 4/13/23 at 10:00 a.m., Resident B's record was reviewed. His diagnoses included, but were not limited to left-sided hemiplegia and hemiparesis (paralysis and weakness), chronic obstructive pulmonary disease (COPD), cerebrovascular disease, diabetes mellitus (DM) (blood sugar disorder), Personal history of traumatic brain injury, major depressive disorder, schizophrenia (disordered thought process with delusions), dementia (degenerative and progressive brain disease), and constipation (unable to have bowel movements). Physician's orders indicated Resident B was on Cymbalta (antidepressant) daily for depression, Risperdal (antipsychotic) and Depakote sprinkles (anticonvulsant) daily for schizoaffective disorder, bipolar type. He had Zofran, as needed for nausea/vomiting. He was a full code. A nursing progress note, dated 4/6/23 at 9:09 p.m., indicated Resident B vomited a large volume after dinner.	F 0684	**F684** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/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/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B no longer resides at the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** Residents who have undergone changes in physical health in the past 30 days have the potential to be affected. Thus, this plan of	05/18/2023

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	A nursing progress note, dated 4/8/23 at 10:35 p.m., indicated Resident B had a change in condition. Licensed Practical Nurse (LPN) 11 did nursing rounds right after report. Resident was lethargic, only responding to a hard sternal rub. Unable to follow commands, unable to grip. His VS were BP 133/75, HR 101, O2 saturation 90% on room air, respirations were even and unlabored at 20, and his temperature was 98 degrees Fahrenheit (F). His physician was notified and received an order to send him out. Emergency Medical Services (EMS) arrived and resident was noted to have a small seizure during that time that lasted approximately 30 seconds. Resident B was sent to a local hospital. A follow-up call with an ER nurse, she indicated Resident B had 3 more seizures in route to the hospital, Keppra (anticonvulsant) was given and the seizures stopped. However, he remained responsive only to a sternal rub and they planned to admit him. A nursing progress note, dated 4/8/23 at 11:00 p.m., indicated Resident B's neurological status evaluation was an altered level of consciousness and seizure. His change in condition warranted an order to be set to ER for further evaluation. His change in condition form, dated 4/8/23, indicated he had an altered mental status with new neurological signs, seizure, and unresponsiveness. His vital signs VS) were blood pressure 133/75, pulse 101, temperature 98 degrees F, and oxygen (O2) saturation 90%. He was a full code. The resident evaluation indicated altered level of consciousness, sudden change in level of consciousness or responsiveness, and new onset seizure. Left eye drooping and only aroused with hard sternal rub. Evening nurse stated he was lethargic at dinner time but was able to consume 100% of dinner and drink all fluids without issue.		correction applies to those residents. An audit of all resident's progress notes for the last 30 days has been completed with any necessary corrections/revisions made accordingly. **3) Measures put into place/ System changes:** Licensed nursing staff will be re-educated relative to Quality of Care, including but not limited to conducting thorough assessments, documentation of those assessments, and prompt physician notification of a change in resident condition. Re-education will be completed by 5/17/23 Director of Nursing (DON), or Designee will review, daily, on scheduled days of work, during clinical meeting, ongoing, progress notes to ensure that appropriate, thorough assessments have been conducted and documented, and physician notifications have been made. Any identified concerns will promptly be addressed with the responsible individual(s). **4) How the corrective actions will be monitored:**	

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	Change in condition warranted an order to be sent to ER for further evaluation. A bowel and bladder incontinence screener, dated 3/7/23, indicated Resident B was always incontinent of bladder and incontinent of bowel 4 to 6 times a week. He was not appropriate for structured bowel and bladder program. He would be placed on a check and change program/standard of care. A risk for constipation care plan, dated 2/9/22, indicated Resident B was at risk for constipation related to his impaired mobility and medication, with a goal to have a bowel movement (BM) at least every 3 days. A nursing approach indicated he needed his medications as order and his BMs monitored by staff to assure he didn't become constipated. A toileting care plan, dated 2/9/22, indicated Resident B needed varied assistance for toileting for bowel and bladder incontinence. An antipsychotic care plan, dated 4/15/22, indicated Resident B had schizoaffective disorder/schizophrenia/mania. A nursing approach indicated he needed his antipsychotic medications as ordered and routine psych visits as needed. During an interview, on 4/13/23 at 2:30 p.m., Registered Nurse (RN) 10 indicated she worked the night shift. Report during change of shifts, LPN 11 indicated the resident was more sleepy than usual after dinner, he did not seem right and he had been vomiting earlier that week. RN 10 indicated after report, she went to Resident B's room first. His room was dark, when she turned on the light, he did not wake up. She grabbed his arm,		The DON/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/12/2023**	

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	but he did not respond. He was unable to grip her hands. He was breathing normally, but his left eye was droopy and he could not open it further. She requested LPN 11 to get his VS. They were within normal limits (WNL). LPN 11 did a hard sternal rub (knuckle pressure on the sternal bone to effect a response from a patient who does not respond to verbal stimuli). He did not respond. RN 10 indicated she got on Diagnotes (email system to reach the nurse practitioner (NP) or medical doctor (MD) to share information about residents) and indicated Resident B was unresponsive and needed to be sent out (to the hospital). She could not find a phone number for the MD. She believed the doctor on-call should have been available to call in an emergency situation. She would have preferred to call the MD instead of waiting for Diagnotes to email her back. The other nurse assisting her was RN 13. We were taking turns in the resident's room. Certified Nursing Aide (CNA) 12 was in the room, so the resident was still being monitored when the nurses were out of the room. RN 10 indicated while she prepared the resident's paperwork, RN 13 called 911. When EMS arrived Resident B had a seizure in his bed, prior to being transferred to the EMS cart. She indicated he was jerking and his arm was up and shaking (his left side was paralysis due to a previous stroke). The seizure lasted about 30 seconds. On 4/14/23 at 9:10 a.m., the Administrator provided a copy of the emailed information through Diagnotes: a. At 9:40 p.m., from LPN 10: Resident B was extremely lethargic. Only responded to a hard sternum rub. VS all WNL. Glucose 156. Request to send out. b. At 9:43 p.m., from Diagnotes, RN 9: Family was requesting? c. At 9:44 p.m., from LPN 10: No, do you want me			

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	to ask family? d. At 9:52 p.m., from Diagnotes, RN 9: Was seeking clarification as to who was requesting. e. At 9:52 p.m., from LPN 10: He is a full code. f. At 9:53 p.m., from Diagnotes, RN 9: Did he take narcotics? g. At 9:54 p.m., from LPN 10: Facility was requesting he be sent out because of a change in condition. h. At 9:56 p.m., from LPN 10: He takes tramadol (for moderate to severe pain). i. At 9:59 p.m., from Diagnotes, RN 9: You may ask family. j. At 10:24 p.m., from LPN 10: We send him out. He started seizing. Unable to reach family. During an interview, on 4/14/23 at 2:40 p.m., RN 13 indicated her assignment that night was on a different hall, but RN 11 requested her help at 10:30 p.m. with Resident B's change in condition. He was not at baseline, he had a significant change in condition. She assessed his level of consciousness. He was unresponsive to a sternal rub, he said an unintelligible word, but his VS and blood sugar (BS) were stable. RN 13 indicated to RN 11 that she should call 911 right away. It is normal for the on-call person to be responding with the NP. We have a number we can call, but we routinely use Diagnotes. Recommended the nurse to communicate on Diagnotes and prepare the resident for transfer. We had been told to use Diagnotes to get a faster response from the providers. The communication from Diagnotes indicated to contact the family. I don't know why the information from Diagnotes wanted us to contact the family. During an interview, on 4/17/23 at 10:59 a.m., CNA 14 indicated she sat with him while the nurses were in and out of the room. He looked like he was			

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	in a deep sleep and his breathing seemed normal. The nurse indicated he looked like he had a stroke because his left eye was drooping. During an interview, on 4/17/23 at 1:54 p.m., LPN 11 indicated she was Resident B's nurse on the evening shift. He got up for dinner and ate in the dining room. A CNA assisted him with eating and he ate 100 % of his meal and drank all the fluids. He was talking, but seemed a little drowsy from being woken up. They lay him down between meals and he was asleep before dinner. He was transferred via a Hoyer lift. As the evening drew longer, at the end of the shift, he laid down and fell back asleep, around 8:00 p.m. The last time she saw him was around 5:30 - 6:00 p.m. She gave him roommate medication around 7:00 or 8:00 p.m., and she noticed he was asleep. She indicated he was more sleepy that usual, but his VS and BS were WNL. She was still at the facility when the night nurse found him unresponsive. He would not respond to verbal stimuli, she did a sternal rub. RN 10 indicated she was going to send him out and LPN 11 agreed with her. During her shift, she did not notice any neurological changes, no tremors or shaking. One of his eyes was normally a little droopy. If she was the nurse when the resident was found unresponsive she would have immediately contacted Diagnotes and then called 911. She would not have waited 1.25 hours before contacting 911. It was a change in condition, he was a different person.. During an interview, on 4/14/23 at 4:17 p.m., the Nurse Consultant indicated Resident B was very dependent on staff. During an interview, on 4/14/23 at 4:18 p.m., the Administrator indicated the daughter indicated in the hospital notes that she doesn't visit him very			

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	often. During an interview, on 4/14/23 at 4:20 p.m., the Director of Nursing (DON) indicated if a resident had a change in condition, the staff should have seen the symptoms, do VS, contact the person on Diagnotes, and wait for their response. If the resident was non-responsive, the staff should have contacted the DON or administrator. Then, complete a change in condition form. An assessment included VS and blood sugar if needed. Vital signs were the main thing to do. She would have called another nurse to help. The nurse would have been on Diagnotes, get the paperwork ready, and calling the family. The time goes by fast. All the steps that have to be done to send a resident out correctly. If the first set of VS were WNL, even if the resident was unresponsive, that would have been enough. Boone County EMS document titled, "Patient Care Report," dated 4/8/23, was provided by Medical Records 15 at Witham Hospital, on 4/18/23 at 2:10 p.m. A review of the document indicated dispatch was notified at 10:59 p.m. Advanced Life Support (ALS) was at the resident's side at 11:06 p.m., where he was found unresponsive. At 11:08 p.m., his BP was 90 palpated (systolic pressure taken by hand), pulse 100, and respirations 24. His Glasgow Coma Scale (GCS) (measure of a person's level of consciousness after a brain injury) was 5 (severe). At 11:14 p.m., his GCS was down to 4. Resident B's O2 saturation was 88%, O2 at 2 lpm (liters per minute) was added via nasal cannula (NC). Patient had sudden onset jerking consistent with a tonic clonic seizure lasting 10-15 seconds. This seizure-like activity happened 3 times within 5 minutes of each other. Patient was moved from the bed to the stretcher. Upon the third bout of			

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	seizure-like activity, patient was given 5 mg Midazolam (versed) (benzodiazepine -slows activity in the brain) IM (intramuscular injection). A current policy, titled, "Assessments," was provided by the Nurse Consultant, on 4/14/23 at 5:00 p.m. A review of the policy indicated, " ...It is the policy of this facility to ensure that assessments of the resident take place timely, at the appropriate time and are accurate ...Appropriate assessment can with will be completed at time based on the event ...Nurses and other qualified health professionals will perform appropriate assessment of the resident as indicated based on the routine schedule as well as when a change in condition or circumstances and/or an event takes place that required ? assessment? by a qualified medical professional ...." This Federal tag relates to Complaint IN00406257. 3.1-37(a)			
F 0919 SS=E Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 6 of 6 random call light observations (Resident C, D, F, G, H, and K).	F 0919	**F919 Reasonable Accommodations Needs/Preferences**	05/18/2023

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	Findings include: Starting on 4/13/23 at 11:10 a.m., random call lights were observed. -Resident K was in bed with his eyes closed, the call light was hanging out of reach away from the side of his bed. -Resident F was in bed with eyes closed. His call light was clipped on the wall behind his bed, it was out of his reach. Starting on 4/14/23 at 1:10 p.m. random call lights were observed. -Resident H was in bed with eyes closed. The call light was observed to be clipped to the wall, behind the bed, out of reach. -Resident G was in bed with eyes closed. His call light was observed to be clipped to the wall, out of reach. -Resident C and D shared a room. Both were asleep in chairs in their rooms. Both call lights were observed on the floor out of reach of the residents. -Resident K was in bed with eyes closed. The call light was observed out of reach, under the edge of the bed. During an interview, on 4/14/23 at 4:29 p.m., the Director of Nursing (DON) indicated the call lights should be answered in less than a minute, but the staff could be working short staffed if it takes longer. Call lights should not be on the floor. There was a clamp attached to the call light so		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/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/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** Residents were not identified to staff during this complaint survey. **2. How the facility identified other residents:** **A**ll residents have the potential to be affected by this cited practice. **3. Measures put into place/ System changes:** Facility staff were re-educated on Reasonable Accommodations Needs/Preferences, including but not limited to, placement of call lights on or before 5/17/23 Department Managers/Designees	

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	that it can be pinned to the resident and should be within their reach. A current policy, titled, "Call Lights," was provided by the Nursing Consultant, on 4/14/23 at 4:39 p.m. A review of the policy, indicated, " ...Always place the call light in an accessible location to where the resident is located in their room ...." This Federal tag relates to Complaint IN00406257. 3.1-19(u)		will complete assigned Guardian Angel Rounds at least 5 times weekly, at varied times, for 4 weeks to ensure resident call lights are within reach. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, Department Managers/Designees will complete Angel Rounds at least 5 times per month at varied times for 2 months to ensure resident call lights are within reach. Any identified concerns will be promptly addressed with the responsible individual(s). 4. Department Managers/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of compliance: 5/12/2023	