STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155483	A. BUILDING 00 B. WING	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RISING SUN, THE	405 RIO VISTA LN RISING SUN, IN 47040

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412098. Complaint IN00412098 - Federal/State deficiency related to the allegation is cited at F580. Unrelated deficiency cited. Survey dates: July 31 and August 1, 2023 Facility number: 000405 Provider number: 155483 AIM number: 100273800 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 7 Medicaid: 32 Other: 11 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, 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 Law. The Facility's date of alleged compliance is 8-22-23. The Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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

Brenda Bannon | Administrator | 08/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician and family related to a resident's behaviors of refusing medications for 1 of 3 residents reviewed. (Resident D) Findings include: The clinical record for Resident D was reviewed on 07/31/23 at 2:45 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/31/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Parkinson's disease, coronary artery disease, and diabetes. The resident received an antidepressant and an opioid for seven of the seven days during the review period. The resident had no hallucinations, delusions, physical or verbal behaviors towards others, or themselves, nor any rejection of care. A Focus Care Plan, with an initiated date of 03/24/21, indicated the resident was resistive/declined care and frequently refused showers and medications. The interventions included, but were not limited to, encourage the resident to take medications to maintain physical and mental health, with an initiated date of 02/24/23; and staff were to inform the MD and family of any changes, with an initiated date of 03/24/21. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for June and July 2023 indicated the resident refused medications on the following dates and times:	F 0580	It is the practice of this facility to consult with/inform the MD and the resident's representative of all changes in condition and need for treatment changes per regulatory guidelines. Resident D s family and doctor were notified of refusal of medications. DON informed the doctor 8-1-23. ADON spoke with daughter to review again on 8-7-23. The DON and/or designee completed a 100% audit on resident records with a 30 day look back to review needs to inform doctor/family of changes in treatment. DON and/or designee updated any needs with doctor and family on 8-18-23 and again 8-21-23. All residents have the potential to be affected. DON in-serviced all nurses on contacting MD and representative and charting after communication with MD and resident representative, including refusal of medications on 8-21-23. Additionally, any nurse who fails to comply with the points of the	08/22/2023

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	- On June 2, 6, 7, 10, and 11 at 8:00 A.M., the resident refused Amlodipine 10 mg (milligrams) once a day for coronary artery disease, Aspirin 81 mg once a day for preventative, Cholecalciferol 50 mcg (micrograms) once a day for vitamin D deficiency, Ferrous sulfate 325 mg once a day for anemia, Multivitamin once a day to promote nutritional health, Omeprazole 20 mg once a day for GERD (Gastroesophageal Reflux Disease), Pimavanserin Tartrate 34 mg once a day for Parkinson's disease related to psychotic disorder with delusions due to physiological condition, Potassium chloride 10 MEQ (Millequivelents) once a day for supplement, Sennoside 8.6 mg two times a day for bowel motility, Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's Disease, 8:00 A.M., June 2, 6, and 7, at 2:00 P.M., Gabapentin 200 mg three times a day for neuropathy, and Hydrocodone-Acetaminophen 5-325 mg three times a day for pain, - On June 2, 6, and 7 at 2:00 P.M., the resident refused Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's Disease, Gabapentin 200 mg three times a day for neuropathy, and Hydrocodone-Acetaminophen 5-325 mg three times a day for pain. There were no signs or symptoms of delusions or hallucinations documented on the resident's June EMAR/ETAR. - On July 5, 8, 9, 14, and 25, at 8:00 A.M., the resident refused Amlodipine 10 mg once a day for coronary artery disease, Aspirin 81 mg once a day for preventative, Cholecalciferol 50 mcg (micrograms) once a day for vitamin D deficiency, Ferrous sulfate 325 mg once a day for anemia,		in-service may be further educated and/or progressively disciplined as indicated. The DON and/or designee will audit EMAR and progress notes informing MD and resident representative with changes in condition/care, including medication refusals per policy 10 per week x 4 weeks, then 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 2 residents per week monthly x 3 months. If the facility is in compliance at the end of 6 months, the monitoring can be discontinued. At the monthly QAPI meetings, monitoring/audits will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan at a minimum of 6 months and/or until resolution is obtained.	

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	Multivitamin once a day to promote nutritional health, Pimavanserin Tartrate 34 mg once a day for Parkinson's disease related to psychotic disorder with delusions due to physiological condition, Potassium chloride 10 MEQ (Millequivelents) once a day for supplement, Sennoside 8.6 mg two times a day for bowel motility, Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's Disease, Gabapentin 200 mg three times a day for neuropathy, and Hydrocodone-Acetaminophen 5-325 mg three times a day for pain. - On July 5, 8, 9, and 14, at 8:00 A.M., the resident refused Omeprazole 20 mg once a day for GERD (Gastroesophageal Reflux Disease). - On July 19 and 26, at 8:00 P.M., the resident refused Mirtazapine 7.5 mg at bedtime for appetite stimulant, Sertraline 50 mg at bedtime for depression, Sennoside 8.6 mg two times a day for bowel motility, Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's Disease, Gabapentin 200 mg three times a day for neuropathy, and Hydrocodone-Acetaminophen 5-325 mg three times a day for pain. There were no signs or symptoms of delusions, depression/withdrawn, or hallucinations documented on the resident's July EMAR/ETAR. The Progress Notes were provided by the Administrator on 08/01/23 at 12:10 P.M., and indicated the resident had refused medications on the following dates and times that were not documented as refused on the EMAR/ETAR: - On July 27, at 9:35 P.M., the resident did not take her "pm" (evening) medications.			

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	- On July 29, at 5:13 A.M., the resident refused her Omeprazole 10 mg. - On July 31, at 5:04 A.M., the resident refused her Omeprazole 10 mg. The EMAR/ETAR and Progress Notes lacked documentation the physician or family had been notified of the resident's refusals to take their medications. During an observation and interview on 08/01/23 at 9:44 A.M., RN 2 administered medications to Resident D. The medications were crushed and in applesauce. The resident took the medications with ease. The RN indicated the resident was not always alert and oriented, had hallucinations at times, and the staff sometimes had difficulty getting the resident to take her medications. If the resident refused her medications, after three attempts, they would destroy the medications. The staff were supposed to put a Progress Note in the resident's record if they refused their medications. If the resident refused her medications, the refusal usually came with a few choice words and that was one of their behaviors. The staff documented either on the EMAR/ETAR or in a Progress Note. They notified the physician through a secured messaging system on the computer at the nurse's station. During an observation and interview with the DON on 08/01/23 at 10:00 A.M., the secured messaging system site was observed on the computer at the nurse's station. There were other residents' messages visible to the physicians back through May of 2023. There were no documented messages related to Resident D provided. The DON indicated the messages sent through the messaging service were not in the residents'			

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	records. The staff would have to put a note in the Progress Notes for any message sent to the physician. The staff should put a note in the Progress Notes of the residents' record any time the physician was notified and the physician's response to the notification, whether the notification was about behaviors or refusals. The current undated "Change in Resident's Condition or Status" policy was provided by the Administrator on 08/01/23 at 12:25 P.M. The policy indicated, "...It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status...The nurse will notify the resident's attending physician when...The resident repeatedly refuses treatment or meds (2 times consecutively or 3 times in a 7 day period)..." This Federal tag relates to IN00412098. 3.1-5(a)(2)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to follow a physician's order in a timely manner related to a Urinalysis for 1 of 3 residents reviewed for laboratory services. (Resident B)	F 0770	It is the practice of this facility to provide or obtain laboratory services to meet the needs of our residents.	08/22/2023

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	Findings include: The clinical record for Resident B was reviewed on 08/01/23 at 3:17 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/17/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, stroke and dementia. The resident had no moods or behaviors identified or documented on the assessment. The Progress Note, dated 07/23/23 at 11:10 A.M., indicated Resident B went into Resident C's room thinking it was his room, got angry, and kicked Resident C's leg. The Progress Note, dated 07/23/23 at 12:50 P.M., indicated Resident B had a new order for a UA (urinalysis) C&S (Culture and Sensitivity) related to increased confusion and behaviors. The Progress Note, dated 07/24/23 at 4:33 P.M., indicated Resident B's specimen for his UA C&S had not been collected for the lab pick up that morning and a new order was placed in the Electronic Health Record. The Progress Note, dated 07/26/23 at 9:42 P.M., indicated the staff documented they were unable to obtain the specimen for the resident's UA C&S. The Progress Notes lacked an indication the physician was notified of the inability to collect the specimen or of any other failed attempts to collect the specimen. A Progress Note, dated 07/27/23 at 12:44 P.M., indicated the specimen for the UA had been obtained (four days after the order was placed in the resident's record).		The DON and/or designee completed a 100% audit of the last 30 days on resident records to review needs to obtain labs. This audit was completed 8-18-23. All residents have the potential to be affected. Resident B s labs were obtained and sent to lab for evaluation. The lab results were negative. MD and family made aware of negative results. DON in-serviced all nurses on expectations for collection of specimens for laboratory orders and timeliness on 8-18-23. Additionally, any nurse who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The DON and/or designee will audit 5 resident charts for lab collection and follow up per week x 4 weeks, then 3 residents per week x 4 weeks, then 2 residents per week x 4 weeks, then 2 residents per week monthly x 3 months. If the facility is in compliance at the end of 6 months, the monitoring can be discontinued. At the monthly QAPI meetings, monitoring/audits will be reviewed,	

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	The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the following physician's orders: - Dated 07/23/2023 at 1:00 P.M., the resident was to have an UA C&S one time only for increased confusion. - Dated 07/24/2023 at 4:45 P.M., the resident was to have an UA C&S one time only for UTI (Urinary Tract Infection), "URINE NEEDS COLLECTED" was added to the note. During an interview on 08/01/23 at 2:50 P.M., the DON indicated following an incident with behaviors, when a resident had an order for a UA, the timeliness of the collection of the specimen would depend on the resident's behaviors. The UA should have been collected within 48 to 72 hours. During an interview on 08/01/23 at 2:59 P.M., the DON indicated the facility had no policy related to the timeliness of obtaining a urine specimen. At 3:57 P.M., the DON indicated the facility did not have any policies related to Lab services. 3.1-25(b)		and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan at a minimum of 6 months and/or until resolution is obtained.	