STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 00 B. WING	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00452313, IN00452187, and IN00451981. Complaint IN00452313: Federal/state deficiencies related to the allegation(s) are cited at F686. Complaint IN00452187: No deficiencies related to the allegation(s) are cited. Complaint IN00451981: No deficiencies related to the allegation(s) are cited. Survey date: February 3, 2025 Facility number: 000174 Provider number: 155274 AIM number: 100274810 Census bed type: SNF/NF: 38 Total: 38 Census payor type: Medicare: 5 Medicaid: 23 Other: 10 Total: 38 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on February 12, 2025.	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview and record review, the facility failed to ensure services were provided to prevent	F 0686	F686 – Treatment/Services to Prevent/Heal Pressure Ulcer Preparation and/or execution of	02/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Walker	HFA	02/14/2025

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	the development of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. A resident's plan of care was not developed with interventions to prevent new pressure from developing after the resident was assessed to be at risk for pressure, and no documentation in the resident's record indicated the resident was turned or repositioned in accordance with physician orders. (Resident D) Findings include: During record review on 2/3/25 at 10:30 A.M., Resident D's diagnoses included, but were not limited to weakness, Parkinson's disease, unspecified abnormalities of gait and mobility, type 2 diabetes, dementia, and urge incontinence. Hospice started when? Admission date? Discharge date? Resident D's most recent admission Minimum Data Set (MDS) assessment, dated 11/27/24, indicated the resident was admitted to the facility with one unhealed Stage I pressure ulcer. (According to the National Pressure Injury Advisory Panel [NPIAP], a Stage I pressure ulcer is defined as: The skin is intact with nonblanchable erythema.) Resident D had moderate cognitive impairment, utilized a wheelchair for mobility, was dependent on two staff for transfers, and required partial assistance to roll from right to left in bed. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 11/22/24, indicated Resident D was at low risk for developing pressure ulcers. Resident D's physician orders included, but were not limited to, turn and reposition every two hours		this plan of correction, in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 2/19/2025. The facility is respectfully requesting paper compliance for all deficiencies in this POC. F868 – Treatment/Services to Prevent/Heal Pressure Ulcers It is the policy of The Waters of Rockport to ensure services are provided to prevent pressure ulcers and care plan developed when a resident is assessed to be at risk for developing pressure ulcers. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident D no longer resides at this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The DON/designee reviewed all residents' skins by 2/19/25 with no new pressure ulcers noted. The DON/designee updated Braden assessments for all	

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	and as needed (started 11/23/24). A Braden scale assessment, completed 11/30/24, indicated Resident D was at moderate risk for developing pressure injuries. A weekly wound assessment note, dated 12/13/24, indicated Resident D had no skin impairment and no wounds. Resident D's care plan included, but was not limited to, Skin integrity impairment (initiated 1/22/25) due to right heel and coccyx ulcer (revised 1/27/25). Resident D's care plan did not include a focus on the resident's risk for developing pressure ulcers following the Braden scale assessment on 11/30/24, nor did it include interventions to prevent the development of pressure ulcers prior to 1/22/25. Resident D's initial wound note dated 1/22/25 indicated Resident D had a new Stage II wound to the right heel that measured 5 cm x 4 cm x 0.1 cm. Resident D's progress notes included, but were not limited to: 1/23/25 at 1:17 P.M. - New pressure area noted to right heel on 1/22/25 by licensed nurse, during care. 1/25/25 at 12:49 P.M. - Resident has an area to the coccyx. A right-side blister measured 4.2 centimeters (cm)(length) x 6 cm (width). A left-side discolored area measured 4.9 cm x 4.3 cm. 1/28/25 at 3:31 P.M. - (Skin and wound note) - Resident was evaluated for a stage II pressure ulcer to right heel and an unstageable pressure ulcer to bilateral buttock. Education on the		residents by 2/19/25. Interventions were implemented for residents that were assessed to be at risk and care plans updated with interventions The MDS Nurse/Coordinator completed an audit for care plans for interventions for all residents on 2/19/2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/designee educated all nursing staff regarding implementing interventions to prevent pressure ulcers by 2/19/25. Any staff that fall to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. The administrator/designee educated the MDS coordinator on the need to ensure care plans are developed and updated with appropriate interventions for residents at risk of skin breakdown on 2/19/2025. How the corrective actions will be monitored to ensure the deficient practice will not recur: The DON/designee will complete an audit to ensure care plans for residents at risk for developing pressure ulcers have interventions in place. This audit will be completed on 10 random	

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	importance of frequent turns while in bed and frequent repositioning while in chair was provided. (According to the NPIAP a Stage II pressure ulcer is defined as: partial-thickness skin loss involving the epidermis and dermis. An unstageable pressure ulcer is obscured by slough or eschar which makes depth and extent of tissue damage unable to be determined.) Resident D's wound assessment report, dated 1/28/25, indicated the following: An unstageable pressure ulcer to the bilateral buttock measured 11 cm x 9.5 cm x 0.1 cm (depth). The wound bed was covered by 80% epithelial tissue and 20% slough. Peri wound was intact, fragile, macerated with edema and erythema (redness and swelling). A moderate amount of serosanguineous exudate was present. A stage II pressure ulcer to the right heel measured 4.5 cm x 6 cm x 0.1 cm. The wound bed was covered by 100% epithelial tissue. Peri wound was intact, fragile, and dry. No drainage was present. A review of Point of Care (POC) CNA charting for the month of January 2025 included documentation that Resident D had been turned and repositioned every two hours starting 1/27/25. No documentation of routine turning and repositioning was found in Resident D's record during the month of January 2025 prior to 1/27/25. During an interview on 2/3/25 at 11:15 A.M., LPN 4 indicated she was working as an aide and that the CNA's should document routine turning and repositioning. During an interview on 2/3/25 at 11:25 A.M., the Director of Nursing (DON) indicated that a change		residents, new admissions, and re-admissions weekly for four weeks, then 5 residents weekly for four weeks, then 5 residents monthly for four months. If the facility is within 95% compliance at the end of six months monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the audit will be reviewed. Any concerns will be corrected as found. If necessary, an action plan will be written by the QAPI committee and will be monitored by the Administrator weekly until resolution is met. Date of Compliance: 2/19/25.	

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	from low risk to moderate risk for developing pressure ulcers would typically trigger an update to the resident's care plan that would include interventions to prevent the development of pressure ulcers. On 2/3/25 at 2:40 P.M., the DON supplied a facility policy titled, "International Guideline (Prevention and Treatment Pressure Ulcers/Injuries: Clinical Practice Guidelines)", dated 10/9/23. The policy included, "...Risk Assessment - A risk Assessment is considered the starting point for prevention of pressure injury... an 'at risk' resident can develop a pressure injury within hours of the onset of pressure. For this reason, the 'at risk' resident must be identified, and have specific interventions put promptly in place and care planned in an effort to prevent formation of pressure injury... Positioning and Mobilization... Turn and reposition resident who are 'at risk' for pressure injury often unless contraindicated. At least every 2 (two) hours is recommended..." This citation relates to complaint IN00452313. 3.1-40(a)(2)			