STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGTON SKILLED NURSING FACILITY, THE	1500 GRANT ST HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00450770, IN00453115, and Complaint IN00454234. Complaint IN00450770-Deficiencies related to the allegations are cited at F684. Complaint IN00453115-No deficiecies related to the allegations are cited. Complaint IN00454234-Deficiencies realted to the allegations are cited at F684. Survey date: March 04, 2025. Facility number: 000020. Provider number: 155059. AIM number: 100288690. Census Bed Type: SNF: 1 SNF/NF: 49 Total: 50 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 6 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 6, 2025.	F 0000	F 684 Supporting documentation has been uploaded regarding the POC. We respectfully request Desk Review. Thank you, Mark Thompson, HFA	
F 0684 SS=D	483.25 Quality of Care			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Thompson	Administrator	04/10/2025

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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Bldg. 00	Based on interview and record review the facility failed to ensure assessments were completed for 3 of 4 residents reviewed with respiratory illness and falls. (Resident J, Resident C and Resident D). Findings include: 1.) Resident J's record was reviewed on 3/4/25 at 12:24 PM. Diagnoses included chronic obstructive pulmonary disease (COPD), anemia and hypertension. A review of Resident J's current quarterly Minimum Data Set (MDS), dated 2/10/25, indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). Resident J declined an interview. A review of Resident J's current care plan titled chronic respiratory illness indicated the resident had a problem of asthma, with a goal date of 5/7/25. Interventions included observing for shortness of breath, cough, increased secretions and notifying the physician when necessary. A review of physician orders dated 2/25/25, indicated prednisone 40 mg was ordered to be given for 4 days, then reduced to 20 mg for 3 days, then 10 mg for 3 days for an upper respiratory infection with wheezing. A review of progress notes, dated 2/14/25 at 7:00 PM, indicated Resident J had a cough and clear breath sounds. Progress notes, dated 2/18/25 at 7:30 PM, indicated Resident J was seen by Nurse Practitioner 8 for a harsh cough with dark, yellow sputum production. The note indicated Resident	F 0684	**F684** It is the intent of this facility to ensure assessments are completed for respiratory illnesses and falls. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The DON/Designee completed a respiratory assessment on Resident J on March 5, 2025, no negative outcome related to the cited practice. The DON/Designee completed an assessment on Residents C and D on March, 5, 2025, with no negative outcome related to the cited practice. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The DON/Designee completed audit for residents exhibiting respiratory symptoms or placed on preventative respiratory medications on March 5, 2025. A respiratory progress was completed daily as needed for the course of the preventative	03/22/2025

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	J had reported symptoms started at the end of the previous week. The Nurse Practitioner indicated Resident J had acute bronchitis and prescribed Augmentin (antibiotic) and prednisone (steroid). Progress note,s dated 2/25/25 at 7:36 PM, indicated Resident J had continued respiratory symptoms, including respiratory wheezes. The Nurse Practitioner recommended completing her course of antibiotics, steroids, and breathing treatments would be increased in frequency. A review of progress notes between 2/14/25 to 3/4/25 did not include any further recording of assessments or vital signs for Resident J. A review of vital sign records indicated Resident J's temperature was 97.5 on 2/13/25 at 10:00 PM and 97.4 on 2/15/25 at 11:55 AM. No additional temperature readings after 2/15/25 were available for review. In an interview, on 3/4/25 at 12:53 PM, Registered Nurse 7 indicated a resident receiving antibiotics for respiratory symptoms should have their breath sounds and temperature checked every shift. A current policy titled Physical Respiratory Evaluation Guidelines, dated 10/24/24, provided by the Director of Nursing on 3/4/25 at 1:55 PM indicated staff should observe the resident's respiratory rate, assess lung sounds, obtain oxygen saturation levels and observe for a cough. The policy did not address documentation guidelines. 2) Resident C's record was reviewed on 3/4/25 at 10:18AM. Diagnoses included non-traumatic brain dysfunction, abnormalities of gait, and weakness.		medication or until symptoms resolved. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** ="" span="">**The DON/Designee in-serviced the nursing staff on completing neuro checks and Fall follow up after falls and completing a respiratory assessment for resident exhibiting symptoms or on preventive medications for respiratory illness on March 5, 2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** ="" span="">The DON/Designee will audit falls for completion of fall assessment and neuro checks five times a week x 4 weeks, then three times a week x 4 weeks, then once a week for 4 months for residents with respiratory symptoms or preventative medications and audit the respiratory assessment for completion.	

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	Resident C's last annual, Minimum Data Set (MDS), dated 12/22/24, indicated their Basic Interview for Mental Status (BIMS) score was 5 (cognitively impaired). The MDS indicated Resident C required physical assistance to perform activities of daily living and the use of a walker. Resident C's progress notes were reviewed with unwitnessed falls documented on the following dates and times; 12/22/24 at 11:20 AM, 1/01/25 at 6:38 AM, 1/6/25 at 3:34 AM, 1/13/25 at 8:51 AM, and 2/8/25 at 2:14 AM. There was no documentation of refusal of neurological checks or reason for missed neurological checks. A neurological checklist started after the fall on 12/22/24. The checklost started at 11:40 AM, The last check was at 1200 noon. No other checks were recorded. There was a note on the form Resident C returned from the hospital on 12/26/24 without a time noted. The form indicated neuro checks should have continued until 12/30/24 but were not completed. A neurological checklist started after the fall on 1/13/25. The checklist started at 8:51 AM, was completed through 5:15 AM, then the following times were not documented. There was an entry at 11:15 PM. Then three non consecutive entries were completed. Three non consecutive entries were one blank. A neurological checklist started after the fall on 2/7/25. The checklist was completed through 2/9/25. A missed entry on 2/10/25 at 7:45AM followed by 2 completed entries. None of the entries dated 2/11/25, 2/12/25, and 2/15/25 were completed.		="" span="">If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **5 By what date the systemic changes for each deficiency will be completed?** **March 22, 2025**	

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	3) Resident D's record was reviewed on 3/4/25 at 10:30 AM. Diagnoses included Parkinson's disease. Resident D's last comprehensive, Minimum Data Set (MDS), dated 10/22/24, indicated their Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). The MDS indicated Resident D required physical assistance to perform activities of daily living and the use of a walker. Resident D's progress notes were reviewed with unwitnessed falls documented on the following dates and times; 10/24/24 at 1:06 AM, 10/24/24 at 9:20 AM, 10/24/24 at 2:01 PM, and 10/28/24 at 6:30 PM. There was no documentation for refusal of neurological checks or reason for missed neurological checks. A neurological checklist started after the fall on 10/24/24 at 12:30 AM. The checklist was completed until 1:15 PM then 3 entries were left blank, and it was resumed at 9:15 PM that evening. Three entries were made, then a missed entry on 10/27/24 at 1:15 PM. There were 2 completed entrees, then the form was marked off as it was indicated Resident D fell 10/28/24. There was no restarting or stopping of the form for the subsequent falls on 10/24/24. A neurological checklist started after the fall on 10/28/24 at 6:30 PM. The form was mislabeled with dates, had 5 blank entries, illegible times and dates the checklist should have been completed. In an interview, on 3/4/25 at 11:14 AM, Licensed Practical Nurse (LPN) 2 indicated neurological checks should be completed on all residents who have an unwitnessed fall or strike their head			

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	during a fall. LPN 2 presented a neurological check form and reviewed the neurological check schedule. She reviewed in detail the expected intervals of neurological assessments. She indicated the neurological check form should be completely filled out with no blank spaces at the end of the monitoring period. She indicated any refusals or missed assessments should be explained in the progress notes. In an interview, on 3/4/25 at 1:06 PM, the Director of Nursing (DON) indicated the neurological checks form should be completed entirely, and any missed assessments should be explained in the Resident's progress notes. The DON acknowledged there was missing documentation in Resident C, and Resident D's neurological check forms presented. A current policy titled "Guidelines for Incidents/Accidents/Falls" was received by the DON on 3/4/25 at 11:11AM. The policy indicated ...2. In the case of a fall, the resident will have a head to toe assessment to include a pain assessment as to any change in their range of motion ability or function. Further, residents who have an unwitnessed fall must have neuro checks started and continued per policy ... This citation is related to complaints IN00450770 and IN00454234. 3.1-37			