STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Rushville Skilled Nursing Facility, The	612 E 11th St Rushville, IN 46173

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 28309 Based on interview and record review, the facility failed to ensure a prescription narcotic was not administered to a resident without an appropriate prescription for the narcotic for 1 of 6 residents reviewed for correct receipt of medications. (Resident C) Findings include: In an interview on 3-19-24 at 9:27 a.m., with a family member of Resident C, she indicated she remained upset that it took over 14 hours before family was notified of the medication error. They told me the nurse did not tell them and they did not find the error until the next day and that I was notified as soon as they were made aware of the error. A progress note for Resident C, dated 2-26-24 at 2:40 p.m. indicated, NP [nurse practitioner] approached AODN [Assistant Director of Nursing] this shift, res [resident] has stated to NP that she had received 2 Tramadol at HS [bedtime] on 2-25-24, ADON [Assistant Director of Nursing] confirmed that res did received [sic] medications, vs [vital signs] obtained, POA [power of attorney], admin [administrator], DON [Director of Nursing], notified, will cont [continue] to monitor for adverse reactions. A progress note, dated 2-27-24 at 3:50 p.m. indicated, IDT [interdisciplinary team] met to address root cause of medication error. Resident was given roommate's medication in error. Nurse counseled on medication error. Resident monitored for adverse effects. In an interview with the Administrator on 3-19-24 at 12:35 p.m., she indicated the facility was unaware of the medication error until the next day (2-26-24). Apparently [name of Resident C] told the nurse practitioner she had slept really well from the two Tramadol tablets she had received the night before. She did not have an order for Tramadol. I can't remember if the Tramadol belonged to her roommate or another resident with the same first name. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Corporate Nurse on 3-19-24 at 4:55 p.m., she indicated Resident C did not have any negative outcomes from the Tramadol. The Corporate Nurse confirmed the facility thinks the medication (Tramadol) was from the resident's roommate, medication supplies. The Corporate Nurse provided a copy of Resident J's Controlled Drug Receipt Record/Disposition Form for her Tramadol 50 milligram (mg), with instructions listed as, take 2 tablets (100 mg) by mouth every 12 hours (scheduled), for dates 2-22-24 to 2-28-24. This form indicated two entries for 2-25-24 at 11:00 p.m., which indicated 2 tablets had been used for both entries, with one of the entries indicating the dose had been destroyed by the administering nurse and co-signed by another staff member as a destroyed dose. When the Corporate Nurse provided the copy of the form, she indicated, You will notice there were two doses signed out for 2-25-24 at 11 p.m. No explanation was provided as to why the initial dose documented on 2-25-24 at 11:00 p.m. was documented as destroyed. A review of the clinical record for Resident C was reviewed on 3-18-24 at 3:44 p.m. Her diagnoses included, but were not limited to an unspecified fracture of the left pubis (pelvic fracture). Her admission Minimum Data Set assessment, dated 2-20-24, indicated she was cognitively intact. A review of her physician orders reflected Resident C had no orders for Tramadol at the time she received the medication. On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a policy, dated February, 2017, and entitled, Medication Administration. This policy indicated its purpose as, To administer all medications safely and appropriately. It indicated, Review the resident's Medication Administration Record (MAR) .Identify resident before administering medication. Explain to resident the type of medication to be administered . Observe the resident for medication side effects and inform the physician if any occur. Document in Nursing Notes. This Federal tag relates to Complaints IN00428105 and IN00429415. 3.1-48(a)(4)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28309 Based on observation, interview and record review, the facility failed to ensure their medication administration error rate remained under five (5) percent during 3 observations with 4 staff and 11 residents. (Residents E,and G) Findings include: 1. During a medication pass observation on 3-18-24 at 4:50 p.m., with Resident E, RN 4 was observed to administer one tablet of omeprazole 20 milligrams (mg). Upon reconciliation of Resident E's physician orders, the order indicated to administer omeprazole 20 mg in the evening at 3:00 p.m. This indicated the medication was given outside of the accepted practice of medications being administered within one hour before or after their scheduled time. In an interview with RN 5 on 3-19-24 at 8:40 a.m., she indicated it was facility policy to administer medications within a one hour window of the scheduled medication administration time. 2. During a medication pass observation on 3-18-24 at 4:59 p.m. with Resident G, RN 4 was observed to administer 4 units of Humalog insulin via a Humalog Kwikpen device subcutaneously into the right deltoid. RN 4 was observed to remove the needle immediately from the skin upon completion of the injection. When queried in regard to this practice, she indicated she was unaware the needle should remain in place for several seconds after the injection. 3. The medication pass observation rate, calculated on 27, opportunities for errors with 2, actual errors, resulted in a medication administration error rate of 7.4 percent. Humalog KwikPen (revised July, 2023) was retrieved on 3-20-24, from the Lilly Pharmaceutical web site. In the section specific to how to use the KwikPen, step 11, indicates, Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle. On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a guideline entitled, Guidelines for Insulin Pens, dated 8-10-23. This document indicated, It is the intent of the facility to monitor, maintain and administer insulin, to include insulin in INSULIN PENS per manufacturer's recommendations and peer physician order. This document did not address any issues with length of time the needle should remain in the skin upon administration. The facility did not provide any manufacturer's recommendations for this particular KwikPen. This Federal tag relates to Complaints IN00428105 and IN00429415. 3.1-48(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28309 Based on observation, interview and record review, the facility failed to ensure infection control measures of handwashing and hand-hygiene were utilized during a medication pass administration observation conducted during 3 observations with 4 staff and 11 residents. (Residents E, F and G,) Findings include: During a medication pass observation on 3-18-24 between 4:50 p.m. and 5:00 p.m., RN 4 indicated she wears gloves for medication passes. Upon completion of medication administrations to Residents E, F and G, RN 4 was observed to remove and discard her gloves, then obtain a single alcohol pad and wipe the palm of each of her hands with the alcohol pad. When queried about this practice, RN 4 responded she did not have any alcohol hand-sanitizer on her medication cart and the large container of alcohol hand-sanitizer was located on the desk at the nurse's station. In an interview on 3-19-24 at 12:35 p.m., with the Administrator, the Administrator was informed of concerns related to handwashing and hand-hygiene practices during a medication pass observation on 3-18-24, with RN 4. The Administrator was notified of concerns related to RN 4, cleansing her hands post glove removal by using a single alcohol wipe to cleanse only the palms of her hands. RN 4, explained she did not use alcohol hand-sanitizer as the only bottle was located at the nurse's station. The Administrator indicated she maintains a supply of personal-sized bottles of alcohol hand sanitizer readily available for use and indicated she (the Administrator) was in the building and available during the 3-18-24 medication pass observation. On 3-19-24 at 1:45 p.m., the Director of Nursing provided a copy of a policy entitled, Medication Administration, dated February 2017. This policy indicated its purpose as, To administer all medications safely and appropriately. It indicated, Wash hands before beginning, whenever you contaminate your hands, and if contact is made with the medication. This policy did not address the use of alcohol-based hand-sanitizer during a medication pass. CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, (November, 2022) was retrieved on 3-20-24 from the Centers of Disease Control (CDC) website. The guidance indicated the following information: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. -Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient ' s immediate environment; After contact with blood, body fluids or contaminated surfaces; Immediately after glove removal. -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. This Federal tag relates to Complaints IN00428105 and IN00429415. 3.1-18(l)