STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lebanon, The	1585 Perry Worth Rd Lebanon, IN 46052

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46414 Based on observation, record review, and interview, the facility failed to ensure a resident had a self-adminstration asessment for a medication (Ventolin) stored at bedside for 1 of 12 residents (Resident 34) reviewed for medications at bedside. Findings include: On 9/10/24 at 10:12 a.m., an inhaler of Ventolin (a bronchodilator) used to treat chronic obstructive pulmonary disease (COPD) was observed on Resident 34's bedside table. Resident 34 was not observed in her room. The medication was left unattended. On 9/10/24 11:28 a.m., a record review was completed for Resident 34. She had the following diagnoses which included but not limited to COPD, heart failure, dementia, and anxiety disorder. She had an order for Ventolin HFA inhalation aerosol solution 108 (90 base) mcg/act (micrograms/actuation) (albuterol sulfate) take two puffs inhale orally every four hours as needed for shortness of breath (SOB). Residnet 34's record lacked a medication self-administration assessment. On 9/10/24 at 11:00 a.m., during an interview with the Director of Nursing, she indicated the medication should not have been left in resident's room. A policy titled, Self-Administration of Medication by Residents with a date of March 2023, was provided by the Director of Nursing (DON) on 9/10/24 at 11:52 a.m. It indicated, An interdisciplinary team determines resident's ability to self-administer medications by means of a skill assessment as follows 3.1-45(a)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46414 Based on and interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately coded for 5 of 12 residents reviewed for resident assessments (Residents 6, 34, 13, 43 and 29). Findings include: 1. On 9/10/24 at 11:16 a.m., a record review was completed for Resident 6. She had the following diagnoses which included, but were not limited to, End Stage Renal Disease (ESRD- disease and degeneration of the kidneys), type 2 diabetes (an inability for the body to produce/process blood sugar), and muscle weakness. She had a physician's order, dated 1/27/24, which indicated she may attend dialysis on Monday, Wednesday, and Friday at a specific center. She had a comprehensive care plan, dated 1/26/24, which indicated she had a diagnosis of ESRD and required dialysis treatment. A Minimum Data Set (MDS) assessment, dated 8/23/24, indicated Resident 6 had not recieved dialysis treatments. 2. On 9/10/24 at 11:35 a.m., a record review was completed for Resident 34. She had the following diagnoses which included, but were not limited to, heart failure, muscle weakness, schizophrenia unspecified, and psychosis (a set of symptoms that can cause a person to lose touch with reality, making it difficult to distinguish what is real and what is not). An undated comprehensive care plan indicated she qualified for classifcation of a Level II related to her diagnosis of schizophrenia, but did not require specialized services. A MDS assessment, dated 5/28/24, was not coded to accuratly reflect her Level II status. 3. On 9/10/24 at 11:05 a.m., a record review was completed for Resident 13. He had the following diagnoses which included but not limited to heart failure, sleep apnea, major depression, chronic kidney disease, and hyperlipidemia (high cholesterol). A MDS assessment, dated 8/19/24, was coded to indicated her recieved an anticoagulant medication. Resident 13's physician orders were reviewed and laked docuemntation that he recieved an anticoagulant medication. During an interview on 9/10/24 at 11:44 a.m., the Regional MDS Consultant (MDSC) indicated, the facility should follow the RAI (Rap Assessment Instrument) for information and guidance related to anticoagulant medication coding. Resident 13 recieved an antiplatlet medication which had been miscoded as an anticogulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37981 4. On 9/11/24 at 11:41 a.m., Resident 43's record was reviewed. His diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), essential hypertension (high blood pressure), and cerebrovascular disease (conditions that affect blood flow to the brain). His quarterly MDS assessment, dated 8/7/24, indicated Resident 43 was on an anticoagulant. His physician orders, dated 7/20/24, indicated Resident 43 had an order for aspirin 81 mg, give 1 tablet one time a day related to cerebrovascular disease and essential hypertension. An anticoagulant was not observed. During an interview, on 9/12/24 at 9:45 a.m., the Director of Nursing (DON) indicated aspirin should not have been coded on the MDS (Minimum Data Set) as an anticoagulant and the MDS Coordinator (MDSC) should have followed the RAI (Resident Assessment Instrument) Manual. During an interview, on 9/12/24 at 10:18 a.m., the Regional MDS Consultant (RMDSC) indicated she went back to the MDS record and changed the aspirin use from anticoagulant to antiplatelet use. A review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17, dated October 2019, was completed. It indicated, .Anticoagulant .Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period .Do not code antiplatelet medications such as aspirin .here 38768 5. On 9/10/24 at 11:00 a.m., Resident 29's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of disease which affect lung tissue and capacity making breathing more difficult), congestive heart failure, and lung cancer. She had a current and active physician order, initiated 7/5/24, to receive hospice services. A nursing progress note, dated 7/6/24 at 9:10 p.m., indicated, . Resident admitted to hospice during previous shift . A comprehensive admission minimum data set (MDS) assessment, dated 7/10/24, indicated Resident 29 did not receive hospice services. During an interview on 9/10/24 at 12:09 p.m., the Regional MDS Consultant, (MDSC) indicated Resident 29's admission MDS should have coded that she received Hospice services since the MDS was dated 5 days after her Hospice services began. At that time, the MDSC indicated, there was no MDS policy, but the facility followed the RAI (Resident Assessment Instrument) guidelines.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38768 Based on observation, interview, and record review, the facility failed to ensure a resident who was at risk for developing pressure ulcers, received a pressure reducing device for her wheelchair for 1 of 2 residents reviewed for pressure ulcers (Resident 29). Findings include: On 9/9/24 at 10:10 a.m., Resident 29 was observed. She was seated in a wheelchair (WC) with her overbed table in front of her. She rested her head in her hand with her eyes closed. No Pressure reducing cushion was observed on her WC seat at that time. On 9/9/24 at 12:33 p.m., Resident 29 was observed. She remained seated in her WC, no pressure reducing cushion was observed, as lunch trays were delivered. On 9/9/24 at 1:23 p.m., Resident 29 was observed. She remained seated in her WC and no pressure reducing cushion was observed in place. On 9/10/24 at 11:00 a.m., Resident 29's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of disease which affect lung tissue and capacity making breathing more difficult), congestive heart failure, and lung cancer. A comprehensive admission Minimum Data Set (MDS) assessment, dated 7/10/24, indicated Resident 29 was at risk for the development of pressure ulcers and required a pressure reducing device for her chair. Resident 29 had an admission comprehensive care plan, dated 7/2024, which indicated, she was at risk for the development of pressure ulcer related to her diagnoses and required interventions which included but were not limited to, follow preventative measures as ordered. During an interview on 9/11/24 at 10:00 a.m., the Director of Nursing (DON) indicated Resident 29 had not come to the facility with a WC, but shortly after her admission to Hospice, she had been evaluated by therapy and was provided a WC with a pressure reducing cushion. The DON indicated Resident 29 should have the cushion on her WC seat and she would go look for it. On 9/11/24 at 10:30 a.m., the DON indicated nursing had not been able to locate Resident 29's cushion and she did not know how long Resident 29 had gone without it. On 9/11/24 at 10:30 a.m., the DON provided a copy of Resident 29's order invoice which indicated a 16-inch gel pressure reducing cushion had been provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 10:30 a.m., the DON provided a copy of current facility policy titled, S-W-A-T Program, Skin Weight Assessment Team Program Meeting Guidance, dated 10/9/23. The policy indicated, .it is the intent of the facility to assess the nutritional status as well as the skin condition status of each resident and to timely address any issues or any potential for issues related to weight and/or skin. The SWAT Team will monito residents who meet the criteria on a weekly basis to ensure that measures are in place to avoid weight loss in at risk for weight loss resident; as well as to avoid skin breakdown in residents at risk for skin breakdown-based on their medical assessments an overall health status . interventions decided upon by the team will be recorded on the individual resident monitoring and record form. The appropriate disciplines will address interventions requiring a physician's order, will have that order obtained. Any new intervention will be added to the resident's care plan 3.1-40(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 Based on record review and interview, the facility failed to assess on a quarterly basis to determine any improvement, decline or remained the same level with mobility and Range of Motion (ROM) for 2 of 3 residents reviewed (Resident 1 and 36). Findings include: 1. On 9/10/24 at 2:04 p.m., a record review was completed for Resident 1. He had the following diagnoses which included but not limited to type 2 diabetes, difficulty walking, heart failure, and history of falling. Resident 1 had undated care plans that indicated he required assistance with his ADLs related to a history of falls, weakness, and decreased mobility. He had an undated care plan that indicated he required a restorative program for Active Range of Motion (AROM) to restore or maintain his functional range of motion (the amount of movement a joint or body part can make, usually measured in degrees). Interventions included to evaluate and revise the program as needed and to notify nursing of decline or improvement for further evaluation, possible therapy and or MD (Medical Director) notification. He had an undated care plan indicating he required a restorative program for dressing/grooming to restore or maintain his ability to dress and undress, bathe, wash, and complete personal hygiene. Interventions included to evaluate and revise the program as needed and to notify the restorative nurse of decline or improvement for further evaluation, possible therapy or MD notification. His record lacked a comprehensive quarterly assessment to measure his extent of movement in his joints and the identification of limitations, along with any improvements, decline, or if he functionally remained at the same level of care. 2. On 9/11/24 at 11:43 a.m., a record review was completed for Resident 36. He had the following diagnoses which included but not limited to difficulty swallowing, difficult speaking, Chronic Obstructive Pulmonary Disease (COPD) (a lung disease that damages the airways and makes it hard to breathe), essential hypertension, and high cholesterol. He had a care plan, dated 3/17/21, that indicated he required a restorative program for dressing/grooming to restore or maintain his ability to dress and undress, bathe, wash and complete personal hygiene tasks. Interventions included to provide the program as scheduled, evaluate and revise the program as needed, and notify the restorative nurse of decline or improvement for further evaluation, possible therapy or MD notification. His MDS, dated [DATE], indicated he did not receive the program as indicated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	His record lacked a comprehensive quarterly assessment to measure his extent of movement in his joints and the identification of limitations, along with any improvements, decline, or if he functionally remained at the same level of care. During an interview with the Regional MDS Consultant on 9/12/24 at 10:44 a.m. She indicated therapy will evaluate and recommend residents to restorative. Certified Nursing Assistants (CNA) provide the restorative programs. They document in Point of Care (POC) but the facility failed to refresh and initiate (pull) into the POC in order for information to transfer to the MDS. They were supposed to do assessments on a quarterly basis. She indicated they were working on performing assessment and checking for minutes. During an interview with the Regional Nurse Consultant on 9/10/24 at 11:44 a.m., the Regional MDS Consultant indicated they followed the Resident Assessment Instrument (RAI) manual for policies pertaining to restorative programs. 3.1-42(a)(1) 3.1-42(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview and record review, the facility failed to ensure a resident received oxygen as ordered for 1 of 1 resident reviewed for Oxygen services (Resident 29). Findings include: On [DATE] at 10:10 a.m., Resident 29 was observed. She was seated in a wheelchair (WC) with her overbed table in front of her. She rested her head in her hand with her eyes closed. An oxygen (O2) concentrator was observed against the wall with tubing in a clear plastic bag. The Nasal Canula (NC) was not in place, and the concentrator was not turned on. On [DATE] at 12:33 p.m., Resident 29 was observed. She remained seated in her WC with her eyes closed. Her O2-concentrator remained off and no O2 was applied to Resident 29. On [DATE] at 1:23 p.m., Resident 29 was observed. She remained seated in her WC with her eyes closed. Her O2 was not in place, and the concentrator remained off. On [DATE] at 10:56 a.m., Resident 29 was observed in bed with her eyes closed. Her O2 was not in place, and the concentrator remained off. On [DATE] at 12:00 p.m., Resident 29 was observed. She remained in bed, but her eyes were open and she indicated she did not feel good. Resident 29 indicated she was uncomfortable, and needed her pants pulled up. She pulled her sheet down and revealed her pants which were pulled down to the middle of her thighs, she indicated the aide forgot to pull them up after she got changed. Resident 29 indicated she was in pain. On [DATE] at 12:02 p.m., Qualified Medication Aide (QMA) 23 was notified that Resident 29 was in pain and needed assistance to pull her pants up. QMA 23 pulled Resident 29's scheduled pain medication and entered her room within five minutes. QMA 23 attempted to help Resident 29 reposition to pull up her pants, but Resident 29 struggled to roll from side to side and quickly became out of breath with her excursion. Resident 29 became frustrated and asked QMA 23 to stop and just give her the medicine. Around that time, Registered Nurse (RN) 13 entered the room to assist QMA 23. RN 13 helped the resident put her hair in a ponytail and resituated her over-bed table within the resident's reach. When Resident 29 was comfortable, RN 13 and QMA 23 left her room, and neither offered to place the oxygen on her before they left. On [DATE] at 9:08 a.m., Resident 29 was observed in bed. Her eyes were open and she indicated she felt much better than she had the day before. Her O2 NC was observed on the floor. On [DATE] at 9:10 a.m., RN 13 indicated Resident 29 had previous orders for O2 to be applied to keep her oxygen saturation level above 90, but RN 13 believed that order had been changed to as needed, since Resident 29 was often noncompliant with wearing her O2. She did not like the way it felt in her nose, and she often pulled the tubing off herself. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:15 a.m., RN 13 entered Resident 29's room. She picked up the O2 canula from the floor and detached it from the concentrator. She tidied the room a little bit before she left and pleasantly engaged with Resident 29. Upon leaving Resident 29's room, RN 13 did not offer placing a new O2 NC. On [DATE] at 11:00 a.m., Resident 29's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of disease which affect lung tissue and capacity making breathing more difficult), congestive heart failure, and lung cancer. She had a current and active physician order to apply O2 via NC every shift at 3 Liters, to maintain oxygen saturations above 90. A comprehensive admission minimum data set (MDS) assessment, dated [DATE], indicated Resident 29 received oxygen services. Resident 29 had an admission comprehensive care plan, dated ,d+[DATE], which indicated she was at risk for complications with gas exchanges related to her diagnosis of lung cancer and that she received oxygen therapy. The care plan lacked revision to include details and/or interventions for her refusals to wear the O2 or noncompliance with oxygen therapy. The care plan lacked revision to include standing or as needed clarification of her physician's order for oxygen therapy. During an interview on [DATE] at 10:00 a.m., the Director of Nursing (DON) indicated, Resident 29 had an order for oxygen therapy to be applied every shift, but it should have been changed to as needed since she did often refuse or was noncompliant with wearing her NC. On [DATE] at 10:30 a.m., the DON provided a copy of current facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, revised [DATE]. The policy indicated, .the comprehensive care plan will further expand on the resident's risks, foals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs. These needs will be defined from observation, interviews, clinical medical record review with the resident, residents; family 3XXX,d+[DATE](a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46414 Based on record review and interview, the facility failed to label tuberculosis testing serum appropriately for 1 of 2 medications rooms reviewed (100 hall). Findings include: On 9/9/24 at 10:38 a.m., a vial of tuberculin serum was observed undated and in the specimen refrigerator. LPN 21 removed the serum from the refrigerator. The freezer was approximately 2 inches deep with ice buildup in this refrigerator. On 9/10/24 at 10:40 a.m., during an interview with the Director of Nursing (DON), she indicated the serum should have been dated when it was opened. A policy titled, Tuberculosis Testing (Mantoux Test), dated March 2023, was provided by the Director of Nursing on 9/10/24 at 11:52 a.m. It indicated, .After a physician's order is secured, acquire the dose necessary from the vial located in the medication refrigerator. If opening a new vial, it must be initiated and dated, as it is only good for 30 days after opening the vial . 3.1-25(j) 3.1-25(m) 3.1-25(n)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37981 Based on observation, interview, and record review the facility failed to ensure effective handwashing of staff delivering lunch trays for 2 of 4 residents observed for receiving lunch trays (Residents 42 and 43). Findings include: On 9/9/24 11:56 a.m., the Social Services Director (SSD) was observed removing Resident 42's lunch tray from the mobile kitchen cart and not using hand hygiene before entering and after leaving his room. A sign on his door indicated to stop because the resident required EBP. The sign indicated, .Everyone must: Clean their hands, including before entering and when leaving the room Then, without using hand hygiene, she returned to the mobile kitchen cart and removed and provided lunch for Resident 43. During an interview, on 9/9/24 at 11:59 a.m., the SSD indicated that she thought she had gelled her hands before entering and after leaving Resident 42 and Resident 43's room. During an interview, 9/9/24 at 12:00 p.m., the Assistant Director of Nursing (ADON) indicated the SSD should have used hand sanitizer before entering and leaving Resident 42 and Resident 43's room. During an interview, on 9/12/24 at 11:27 a.m., the Director of Nursing (DON) indicated Resident 42's roommate, Resident 43, had enhanced barrier precautions because he had a suprapubic catheter (urinary drainage system). On 9/11/24 at 11:46 a.m., Resident 43's record was reviewed. His physician order, dated 7/20/24, indicated, . Enhanced Barrier Precautions ever shift for catheter A current policy, titled, Guidelines for Enhanced Barrier Precautions - (EBP), An extension of Personal Protective Equipment - (PPE), dated December 2022, was provided by the DON, on 9/11/24 at 2:10 p.m. A review of the policy indicated, .Proper hand hygiene is a critical requirement in all aspects of resident care to include any precautions such as Universal/Standard/Contact/Droplet/Airborne as well as Enhanced (EBP) 3.1-21(i)(2) 3.1-21(i)(3)