STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on observation, interview, and record review, the facility failed to notify the physician in regard to a need to alter treatment for 2 of 5 residents reviewed for unnecessary medications. The physician was not notified of resident's elevated blood sugar readings and elevated weights. (Resident 30, Resident L, Resident J, Resident F) Findings include: 1. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, atherosclerotic heart disease, hypertension (HTN), and edema. Resident 30 was admitted on [DATE]. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, was on a therapeutic diet, had a significant weight gain, and was given insulin. Physician's Orders included, but were not limited to, the following: Weekly Weight in the morning every Monday for edema, start date 7/17/2024 Daily weight in the morning related to edema. Notify provider of weight >3 lbs/24 hours(greater then 3 lbs in 24 hours), start date 9/18/24 Dexcom G7 Sensor (continuous glucose system), inject 1 device subcutaneously one time a day every 10 days related to diabetes mellitus type II. Replace sensor every 10 days. Resident has receiver, start date 7/18/24 Lispro Insulin 100 units/ml (milliliter) solution, inject as per sliding scale: 0-100=0 unit, 101-150=1 unit, 151-200 =4 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=22 units, subcutaneously three times a day, start date 6/9/24 and discontinued 7/17/24 Lispro Insulin 100 units/ml (milliliter) solution, inject as per sliding scale: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	0-100=0 unit, 101-150=1 unit, 151-200 =4 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=22 units, subcutaneously three times a day, start date 7/17/24 A current Diabetes Care Plan, dated 6/19/24, included, but was not limited to, the following interventions: Notify MD (Medical Doctor) as needed, initiated 6/19/24 A current Obesity/Nutritionally compromised Care Plan, dated 6/7/24, included, but was not limited to the following interventions: Monitor weight per facility protocol, initiated 6/7/24 The June 2024 MAR (Medication Administration Record) was reviewed for blood sugars from 6/6/24 through 6/30/24 and indicated the following: On 6/14/24 at 5:00 P.M., Resident 30's blood sugar was 513 mg/dL (milligrams per deciliter) and indicated to see nurse's note. On 6/22/24 at 12:00 P.M., Resident 30's blood sugar was 450 mg/dL and indicated to see nurse's note. The July 2024 MAR was reviewed for blood sugars from 7/18/24 through 7/31/24 and indicated the following: On 7/19/24, Resident 30 was out of the facility for her blood sugar reading at 12:00 P.M. At 5:00 P.M. that evening, her blood sugar was 450 mg/dL. On 7/21/24 at 12:00 P.M., Resident 30's blood sugar reading was 96 mg/dL and indicated to see nurse's note. On 7/22/24, Resident 30 was out of the facility for her blood sugar reading at 12:00 P.M. At 5:00 P.M. that evening, her blood sugar was 302 mg/dL. The August 2024 MAR was reviewed for blood sugars from 8/1/24 through 8/31/24 and indicated the following: On 8/16/24 at 7:00 A.M., Resident 30's blood sugar reading was 458 mg/dL and indicated to see nurse's note. On 8/26/24 at 5:00 P.M., MAR was blank. On 8/29/24 at 7:00 A.M., Resident 30's blood sugar reading was 540 mg/dL and indicated to see nurse's note. On 8/29/24 at 12:00 P.M., Resident 30's blood sugar reading was 540 mg/dL and indicated to see nurse's note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 30's weights were reviewed from 5/31/24 through 9/25/24 and indicated the following: 5/31/24 2:36 P.M. 217.4 Lbs (pounds) 6/27/24 4:56 P.M. 256.0 Lbs (weight gain of 38.6 lbs) 7/1/24 2:12 P.M. 265.4 Lbs (weight gain of 9.4 lbs) 7/10/24 6:55 A.M. 263.0 Lbs (weight loss of 2.4 lbs) 7/11/24 5:30 A.M. 265.0 Lbs (weight gain of 2.0 lbs) 7/11/24 1:21 P.M. 266.0 Lbs (weight gain of 1.0 lbs) 7/12/24 10:26 A.M. 267.2 Lbs (weight gain of 1.2 lbs) 7/22/24 6:02 A.M. 273.4 Lbs (weight gain of 6.2 lbs) 7/25/24 10:28 A.M. 179.0 Lbs On 8/6/2024 2:07 P.M. noted Incorrect Documentation 8/5/24 1:09 P.M. 269.2 Lbs (weight loss of 4.2 lbs) 8/6/24 2:07 P.M. 272.6 Lbs (weight gain of 3.4 lbs) 8/6/24 2:07 P.M. 272.6 Lbs (weight gain of 3.4 lbs) 8/16/24 12:56 A.M. 278.0 Lbs (weight gain of 6.0 lbs) 8/19/24 9:44 A.M. 285.6 Lbs (weight gain of 7.6 lbs) 9/2/24 10:38 A.M. 313.8 Lbs (weight gain of 28.2 lbs) 9/9/24 11:09 A.M. 306.6 Lbs (weight loss of 7.2 lbs) 9/16/24 10:51 A.M. 340.6 Lbs (weight gain of 34 lbs) 9/18/24 10:02 A.M. 333.6 Lbs (weight loss of 7.0 lbs) 9/19/24 7:40 A.M. 334.0 Lbs (weight gain of 0.4 lbs) 9/20/24 7:54 A.M. 320.4 Lbs (weight loss of 13.6 lbs) 9/21/24 12:19 P.M. 317.6 Lbs (weight loss of 2.8 lbs) 9/22/24 9:04 A.M. 318.4 Lbs (weight gain of 0.8 lbs) 9/23/24 12:01 P.M. 317.6 Lbs (weight loss of 0.8 lbs) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/24/24 8:53 A.M. 311.6 Lbs (weight loss of 6.0 lbs) 9/25/24 5:30 A.M. 318.4 Lbs (weight gain of 7.2 lbs) Progress notes for June 2024 were reviewed and lacked documentation in the nursing notes regarding the elevated blood sugars. Progress notes for July 2024 were reviewed and lacked documentation about the resident's blood sugar and insulin administration while she was out of the facility and documentation in the nursing notes regarding the elevated blood sugars. There was no documentation noting weight change/error from 7/22/24 to 7/25/24 or from 7/25/24 to 8/5/24. Progress notes for August 2024 were reviewed and lacked documentation in the nursing notes regarding the elevated blood sugars. Progress notes for September 2024 were reviewed and lacked documentation of the physician being notified of weight changes 9/18/24, 9/20/24, 9/24/24, or 9/25/24. A Care Plan Meeting Note, dated 9/11/24, lacked documentation that significant weight gain and uncontrolled blood sugars were discussed. Recent lab results from 6/26/24 were reviewed indicated Resident 30 had an A1C blood test (tests the average of resident's blood sugars over the past 3 months) of 7.9% (greater than 6.5 is considered diabetic level). On 7/24/24, Resident had a fasting glucose (blood sugar) of 426 mg/dL (normal 65-99). There was a typed note on the bottom of the blood work results from (Name of Nurse Practitioner) indicating BS [blood sugars] out of control . remind me to look at next time I'm there. , dated 7/27/24 The clinical record lacked documentation that the resident's diabetes care had any changes after 7/27/24. During an observation on 9/27/24 at 8:24 A.M., RN (Registered Nurse) 3 weighed Resident 30 on a sit down chair scale. The resident's buttocks was hanging over the armrests of the chair. The scale indicated she weighed 324.0 lbs. RN 3 indicated to the resident her weight went up since the previous day. At that time, RN 3 said ideally they should weigh residents before breakfast. She indicated Resident 30 was a diabetic and had excessive weight gain so they are watching her weight closely. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was unsure who was putting in the orders and care plans prior to her employment (8/12/24), but for her insulin sliding scale should indicate to call the physician if blood sugars were over 450 mg/dL. She would expect staff to notify the physician of a blood sugar higher then 450 mg/dL. She indicated the resident's cognition was intact and she bought food, overate, and snacked on things that she shouldn't, which was her right, so it was hard for the dietician, physician, nurse practitioner, and staff to know if the weight fluctuations were due to medications, fluid retention, error in weighing resident, or another medical condition. She indicated they tried to educate Resident 30, but she was not making better decisions about what she ate or how much. Any communication or documentation done should be put in a nurse note in progress notes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/24 at 3:14 P.M., the DON indicated they don't have a policy, but it would be their policy to follow orders and care plans. She indicated they did not have a policy for monitoring weights of residents, but they should be weighed before they have breakfast and if the weight gain or loss was significant, more than 3 lbs, the resident should be re-weighed and physician notified during that shift. 45933 2. On 9/25/24 at 1:46 P.M., Resident L's clinical record was reviewed. Diagnoses included, but was not limited to, anxiety disorder and diabetes mellitus. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident L had severe cognitive impairment and received insulin injections. Current Physician Order's included, but was not limited to: .HumaLOG Injection Solution 100 UNIT/ML [milliliter] (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously three times a day for Diabetes related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION .Do not give insulin before eating. Wait to administer insulin until after eating or at least 50% of the meal is consumed. AND Inject 5 unit subcutaneously three times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION .Pharmacy Active 8/21/2024 . .Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 23 unit subcutaneously in the evening for Hyperglycemia related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION .Pharmacy Active 8/21/2024 . .Accu-check before meals and at bedtime four times a day .Active 7/15/2024 . Resident L's clinical record lacked current blood sugar parameters to notify the Physician. Resident L's current care plans included, but was not limited to, .Diabetes with risk for Hypo/or Hyperglycemia . with interventions to obtain blood sugars per the order and to notify the Physician as needed. Resident L's MAR (Medication Administration Record) was reviewed for August 2024 and September 2024 and lacked notification of high blood sugars to the Physician on the following dates and times: On August 1 at 7:00 A.M., Resident L's blood sugar was 450. On August 3 at 7:00 A.M., Resident L's blood sugar was 579. On August 5 at 7:00 A.M., Resident L's blood sugar was 405. On August 9 at 4:00 P.M., Resident L's blood sugar was 500. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 9 at 8:00 P.M., Resident L's blood sugar was 500. On August 11 at 7:00 A.M., Resident L's blood sugar was 566. On August 10 at 11:00 A.M., Resident L's blood sugar was 494. On August 15 at 7:00 A.M., Resident L's blood sugar was 568. On August 15 at 11:00 A.M., Resident L's blood sugar was 439. On August 20 at 8:00 P.M., Resident L's blood sugar was 489. On August 21 at 7:00 A.M., Resident L's blood sugar was 501. On August 21 at 4:00 P.M., Resident L's blood sugar was 499. On August 23 at 4:00 P.M., Resident L's blood sugar was 501. On August 25 at 7:00 A.M., Resident L's blood sugar was 570. On August 30 at 4:00 P.M., Resident L's blood sugar was 548. On September 1 at 11:00 A.M., Resident L's blood sugar was 215. On September 2 at 4:00 P.M., Resident L's blood sugar was 476. On September 7 at 7:00 A.M., Resident L's blood sugar was 423. On September 8 at 4:00 P.M., Resident L's blood sugar was 541. On September 9 at 7:00 A.M., Resident L's blood sugar was 600. On September 9 at 4:00 P.M., Resident L's blood sugar was 405. On September 9 at 11:00 P.M., Resident L's blood sugar was 405. On September 10 at 11:00 A.M., Resident L's blood sugar was 499. On September 12 at 11:00 A.M., Resident L's blood sugar was 458. On September 13 at 4:00 P.M., Resident L's blood sugar was 407. On September 22 at 4:00 P.M., Resident L's blood sugar was 503. On September 23 at 11:00 A.M., Resident L's blood sugar was 484. On September 24 at 4:00 P.M., Resident L's blood sugar was marked Not Applicable. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/27/24 at 12:26 P.M., the ADON (Assistant Director of Nursing) indicated staff should notify the Physician if Resident L's blood sugar is over 400, and document the notification in progress notes. During an interview on 9/30/24 at 10:07 A.M., the DON (Director of Nursing) indicated staff should have documented in the progress notes that they notified the Physician of a blood sugar higher than 400, and it was not done. At that time, she indicated parameters should be documented in Resident L's chart on when to notify the Physician. 3. On 10/1/24 at 10:05 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of the right lower limb. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 9/23/24, indicated no cognitive impairment, always incontinent of urine, frequently incontinent of bowel, and required extensive assistance of two with toileting. Physician orders included, but were not limited to: Stool occult with culture and sensitivity if indicated, every 12 hours for infection control until completed, dated 8/30/24, and started 9/2/24. The clinical record lacked stool occult test results, or information that the stool was sent to the lab for testing. On 10/1/24 at 9:52 A.M., Registered Nurse (RN) 3 indicated a sample was collected for the occult test at some point, but the lab said it was in the wrong container and they would have to bring the correct one to the facility. It took them about a week to bring the correct container and by that time, the diarrhea was gone. On 10/1/24 at 11:08 A.M., the Director of Nursing (DON) indicated Resident J's stool sample had not been obtained when ordered because the bed sheets would soak it up when the resident had diarrhea. She indicated the physician should have been notified after a couple of missed stools that they were not able to obtain it for the test, and at this point the order for the test should be discontinued as she stopped having diarrhea. 4. On 9/27/24 at 10:47 A.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, obstructive uropathy. The most recent Discharge MDS (Minimum Data Set) Assessment, dated 9/14/24, indicated an indwelling catheter and frequent bowel incontinence. Cognition status was not assessed. Physician orders included, but were not limited to: Cefepime HCl Infection Solution Reconstituted 1 GM (gram), use 50 ml (milliliter) intravenously every 6 hours for UTI for 7 days, reconstituted with 50 ml normal saline, dated 9/19/24 through 9/25/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident F's Medication Administration Record (MAR) for September 2024 indicated Cefepime was not administered as ordered on the following dates/times: 9/19/24 at 12:00 A.M. 9/19/24 at 6:00 A.M. 9/20/24 at 12:00 P.M. 9/25/24 at 12:00 P.M. Resident F's clinical record lacked physician notification of the missed doses of Cefepime, or any investigation into why the medication was missed. On 9/30/24 at 9:50 A.M., the Director of Nursing (DON) indicated the physician had not been notified of Resident F's missed doses of Cefepime. On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Medication Administration Errors policy that indicated Administration-based medication errors Examples include but are not limited to . Missed medication . Upon identification of a medication error the facility will . Notify the physician and family of the medication error On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Notification policy that indicated Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments - related to the notification On 9/30/24 at 12:30 P.M., a current Guidelines for Notification of Change in Resident's Condition/Status/Treatment policy, dated 6/29/24 indicated, It is the intent of the facility to ensure that .their attending physician .notified of changes in the resident's condition, status, or treatment. This notification will be done promptly in order to obtain any orders needed for appropriate treatment and/or monitoring related to the change . On 9/30/24 at 3:00 P.M., the DON provided a current, undated, Blood Glucose Monitoring policy that indicated, .Blood sugars found to be below 70 or above 400 will be reported immediately to the physician and the resident's representative. Any orders received from the physician will be implemented .Notify physician if blood glucose is outside resident's parameters for blood glucose as ordered by their physician .Immediately notify the physician and the resident's representative any time the resident's blood sugar is outside the ordered parameter range as well as any interventions taken .complete all appropriate documentation. 3.1-5(a)(2) 3.1-5(a)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 5 residents reviewed for unnecessary medications. A resident's clinical record lacked an antianxiety, antipsychotic, antiplatelet, and diabetes care plans. A resident's clinical record lacked a care plan for smoking and an order to add NAS (no added salt) to a resident's diet was not implemented. (Resident 18, Resident 30) Findings include: 1. On 9/26/24 at 2:57 P.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, other arterial embolism and thrombosis of abdominal aorta, generalized anxiety disorder, borderline personality disorder, and bipolar disorder. Resident 18 was admitted [DATE]. The most recent Admission MDS (Minimum Data Set), dated 7/22/24, indicated Resident 18 was cognitively intact, an extensive assist of 2 staff for bed mobility, transfers, toileting, and was administered antianxiety, antipsychotic, antiplatelet, and hypoglycemic medications. Current Physician's Orders included, but were not limited to, the following: Latuda (antipsychotic) 20 mg (milligrams) tablet, give 20 mg by mouth one time a day related to borderline personality disorder, ordered 7/16/2024 Buspar (antianxiety) 5 mg tablet, give 5 mg by mouth three times a day for anxiety, ordered 7/15/2024 Aspirin (antiplatelet) 325 mg tablet, give 325 mg by mouth one time a day related to other arterial embolism and thrombosis of abdominal aorta, ordered 7/16/2024 Jardiance (diabetes) 10 mg tablet, give 10 mg by mouth in the morning related to diabetes mellitus type II, ordered 8/13/2024 Metformin (diabetes) HCL (hydrochloride) 1000 mg tablet, give 1000 mg by mouth every morning and at bedtime related to diabetes mellitus type II, ordered 7/16/2024 The clinical record lacked an antianxiety, antipsychotic, antiplatelet, and a diabetic care plan. 2. During an interview on 9/27/24 at 7:51 A.M., Resident 30 indicated she vaped (electronic cigarette) and had to watch her salt intake. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), atherosclerotic heart disease, hypertension (HTN), and nicotine dependence. Resident 30 was admitted on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, was on a therapeutic diet, and her smoking status was not indicated. Current Physician's Orders included, but were not limited to, the following: Con Cho (Consistent Carbs) diet, regular texture, thin liquids consistency, ordered 5/31/24 A current At Risk for HTN Care Plan, dated 6/18/24, included but was not limited to the following intervention: Provide diet as ordered and encourage resident to follow RD recommendations Progress notes included, but were not limited to, the following: On 9/19/24 at 2:15 P.M., a Dietary Progress Note indicated, Monitoring for: Significant weight gain . wt [weight] Change: gain of 27 pounds in 1 week. Diet: CCHO [Carb Consistent]; regular; thin liquids . Resident reviewed on NAR [Nutrition Assessment Review] for significant weight gain. Gain of 27 pounds in 1 week, which may be fluid-related. Per DON, resident with increased edema and excess swelling to breast. Eating well. Plan/Monitoring: Continue monitoring the resident's weight and PO intake. Recommendation: add NAS restriction to the diet. The clinical record lacked a smoking/vaping care plan for the resident. The clinical record lacked a current NAS restriction for Resident 30's diet. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was unsure who was putting in the orders and care plans prior to her employment (8/12/24), but there should be a care plan for smoking in Resident 30's clinical record and an antianxiety, antipsychotic, antiplatelet, hypoglycemic, and diabetes care plans for Resident 18. During an interview on 9/30/24 at 2:40 P.M., the DON indicated the NAS diet recommendation from the dietician's note on 9/19/24 should have went into effect immediately, but it was missed. She indicated the physician would not have to sign off on that order before it would go into effect. The current process was that an email would be sent from the dietician to the DON/ADON (Assistant Director of Nursing) to put that order in and notify dietary. At that time, the DON indicated they don't have a policy, but it would be their policy to follow orders and care plan interventions. (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:30 P.M., a current Baseline/Comprehensive Care Plan Policy, revised 9/18/18, was provided by the DON and indicated, . The comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables [sic] to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs . The facility Interdisciplinary Team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with a hands on caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident . The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive MDS assessments . 3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38770 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and a comprehensive person-centered care plan for 1 of 1 residents reviewed for bowel and bladder incontinence. Physician orders were not followed, physician was not notified related to change in condition, treatments were being done without an order, care plans were not updated, and wound assessments were not completed. (Resident J) Findings include: On 10/1/24 at 10:05 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of the right lower limb. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 9/23/24, indicated no cognitive impairment, always incontinent of urine, frequently incontinent of bowel, and required extensive assistance of two with toileting. Physician orders included, but were not limited to: Stool occult with culture and sensitivity if indicated, every 12 hours for infection control until completed, dated 8/30/24, and started 9/2/24. Linezolid Oral Tablet 600 mg (milligram) every morning and at bedtime for bacterial skin infection to the leg/cellulitis, from 8/20/24 through 8/29/24. Triad Hydrophilic Wound Dress External Paste (Wound Dressings), apply to buttocks topically every shift for MASD (moisture-associated skin damage), apply with every incontinent episode, dated 5/1/24. Aquaphor Advanced Therapy External Ointment (Emollient), apply to bilateral legs and face topically at bedtime for extremely dry skin, , dated 5/1/24. Apply Miconazole powder to right gluteal fold every shift for skin integrity until healed, dated 4/24/24. A current impaired skin integrity care plan for maceration/moisture to abdominal folds, under breasts, and coccyx, dated 4/23/24, indicated to notify physician as needed, treatments as ordered, and weekly skin checks, all dated 4/23/24. A current risk for skin impairment care plan related to bilateral lower extremity cellulitis, dated 9/27/24, indicated resident was dependent on staff assistance for bed mobility and transfers. Interventions included, but were not limited to, keep clean and dry, skin assessment per facility policy, and treatments as ordered, all dated 9/27/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes indicated Resident J was in the hospital from 8/17/24 through 8/20/24 and diagnosed with sepsis and cellulitis of right lower extremity. Resident J was readmitted with an antibiotic order of Linezolid 600 mg twice a day for bacterial skin infection to the leg/cellulitis, dated and administered from 8/20/24 through 8/29/24. Progress notes included, but were not limited to, the following: 8/20/24 at 11:35 A.M. A nures's note indicated Resident J had returned from the hospital with no new skin issues noted. Redness continued to folds with powder and Interdry (fabric type dressing) in place. 8/29/24 at 8:11 A.M. A nurse's note indicated Resident J was noted to have an adverse reaction to an antibiotic evidenced by loose stool with frequent slimy consistency. The Nurse Practitioner (NP) was notified. 8/30/24 at 9:45 A.M. An Interdisciplinary Team (IDT) note indicated a new skin area was identified related to maceration, diarrhea, and current cellulitis infection. New skin orders were in place. 8/30/24 at 10:29 A.M. A nurse's note indicated a new order was received from the NP for a stool occult specimen with culture and sensitivity if indicated. 8/30/24 at 11:47 A.M. A nurse's note indicated Resident J was having frequent loose stools, and the recommendation from the resident's provider was to keep clean and dry, and follow wound care orders. 9/4/24 at 2:11 A.M. A physician note indicated Resident J had experienced recent episodes of loose stool causing gaulding to peri/buttock area. 9/4/24 at 11:13 A.M. A physician note indicated Resident J was noted to have increased fungal appearance rash to buttocks following diarrhea related to antibiotic use. Resident J's Medication Administration Record (MAR) for September 2024 indicated a stool sample was ordered and not obtained (not signed off on) with no indication why on the following dates/times: 9/2/24 at 6:00 P.M. 9/3/24 at 6:00 A.M. 9/11/24 at 6:00 A.M. 9/18/24 at 6:00 A.M. 9/25/24 at 6:00 A.M. and 6:00 P.M. Resident J's September 2024 MAR indicated a stool sample was obtained on 9/6/24 at 6:00 A.M. and on 9/30/24 at 6:00 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked stool occult test results, or information that the stool was sent to the lab for testing. Resident J's September 2024 MAR for the remaining dates from 9/2/24 through 9/30/24 indicated a stool sample was not obtained with an indicator to see nurse's notes. Progress notes related to e-mar administration included the following: 9/5/24 at 5:17 A.M. waiting for collection vial for lab. 9/5/24 at 5:13 P.M. no BM 9/7/24 at 5:56 P.M. sample not obtained. 9/8/24 at 5:44 P.M. specimen not obtained. 9/10/24 at 5:49 P.M. no BM. 9/11/24 at 6:03 P.M. no BM on this shift. 9/12/24 at 6:12 A.M. no stool noted. 9/13/24 at 6:05 P.M. specimen not obtained. 9/14/24 at 5:39 P.M. no BM this shift. 9/15/24 at 6:05 P.M. no BM this shift. 9/16/24 at 6:14 P.M. specimen not obtained. 9/17/24 at 6:30 P.M. no sample. 9/18/24 at 5:41 P.M. no BM this shift. 9/19/24 at 5:36 A.M. no bm this shift. 9/19/24 at 5:22 P.M. no BM. 9/20/24 at 6:42 A.M. no BM observed this shift. 9/21/24 at 5:40 P.M. specimen not obtained. 9/22/24 at 6:26 P.M. no sample. 9/24/24 at 5:33 P.M. no BM. 9/26/24 at 6:33 A.M. no stool noted. 9/27/24 at 6:25 A.M. no BM noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/28/24 at 5:15 P.M. no BM noted. 9/29/24 at 5:32 P.M. no BM noted. Resident J's clinical record lacked a nurse's note for the following dates: 9/3/24 at 6:00 P.M. 9/4/24 at 6:00 A.M. and 6:00 P.M. 9/6/24 at 6:00 A.M. and 6:00 P.M. 9/7/24 at 6:00 A.M. 9/8/24 at 6:00 A.M. 9/9/24 at 6:00 A.M. and 6:00 P.M. 9/10/24 at 6:00 A.M. 9/12/24 at 6:00 P.M. 9/13/24 at 6:00 A.M. 9/14/24 at 6:00 A.M. 9/15/24 at 6:00 A.M. 9/16/24 at 6:00 A.M. 9/17/24 at 6:00 A.M. 9/18/24 at 6:00 A.M. 9/20/24 at 6:00 P.M. 9/21/24 at 6:00 A.M. 9/22/24 at 6:00 A.M. 9/23/24 at 6:00 A.M. and 6:00 P.M. 9/24/24 at 6:00 A.M. 9/25/24 at 6:00 A.M. and 6:00 P.M. 9/26/24 at 6:00 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/27/24 at 6:00 P.M. 9/28/24 at 6:00 A.M. 9/29/24 at 6:00 A.M. 9/30/24 at 6:00 P.M. A weekly skin check, dated 8/30/24, indicated resident did not have current loss of skin integrity, but had experienced a new loss of skin integrity. The form indicated a weekly wound evaluation was required for each area of loss of skin integrity. The clinical record lacked a weekly wound evaluation for the new areas listed on the 8/30/24 weekly skin check. A change in condition evaluation, dated 8/30/24, indicated Resident J had a new skin wound identified on 8/29/24 due to having loose stools related to the antibiotic Linezolid. A wound evaluation, dated 8/22/24, indicated Resident J had maceration to the left lower leg fold that was identified on 8/20/24 with a current treatment of Interdry daily. The clinical record lacked a current or discontinued order for Interdry. The clinical record lacked a notification to the physician related to inability to get a stool sample. On 10/1/24 at 9:48 A.M., Certified Nurse Aide (CNA) 9 indicated Resident J used a bedpan for bowel movements and usually went once a day. He indicated he was unaware of any stool tests that needed to be completed, and that was something nursing would take care of. On 10/1/24 at 9:52 A.M., Registered Nurse (RN) 3 indicated she was aware of the stool test for Resident J, but the resident was no longer having diarrhea. She indicated the CNAs were supposed to notify the nurses if Resident J had a bowel movement. She indicated a sample was collected for the occult test at some point, but the lab said it was in the wrong container and they would have to bring the correct one to the facility. It took them about a week to bring the correct container and by that time, the diarrhea was gone. She indicated the loss of skin integrity that Resident J experienced on 8/30/24 was from moisture associated with incontinence and diarrhea, would notify staff when she needed to be changed, and used a bed pan for bowel movements. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 11:08 A.M., the Director of Nursing (DON) indicated Resident J had been in the hospital from 8/17/24 through 8/20/24 and came back to the facility on an antibiotic that caused diarrhea which then resulted in her skin getting macerated. She indicated staff was using barrier cream on the areas, then changed to powder which has helped. She indicated the stool sample had not been obtained when ordered because the bed sheets would soak it up when the resident had diarrhea as she was not using a bed pan. She indicated the physician should have been notified after a couple of missed stools that they were not able to obtain it for the test, and at this point the order for the test should be discontinued as she stopped having diarrhea. She indicated the wound evaluation on 8/22/24 reflected areas behind both knees as well as gluteal folds. All areas had Interdry to keep them dry and were currently being changed daily and/or when soiled. She indicated there should have been an order in place for the Interdry, and was unsure why there was not a current order. She indicated she was unsure what area the weekly skin check dated 8/30/24 was for as there were no new areas at that time that hadn't been already identified. She indicated Resident J's skin integrity care plans should have been updated when she came back from the hospital on 8/20/24 with the new skin issues. At that time, the DON indicated there was no current facility policy related to wound management, but that it would be the facility's policy to follow physician orders, and to receive an order prior to implementing a treatment. On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Notification policy that indicated Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments - related to the notification This Federal tag relates to Complaint IN00442764. 3.1-37(a)

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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. 38770 Based on interview and record review, the facility failed to ensure measures to heal existing pressure ulcers and prevention of additional pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. Care plan interventions were not followed, orders were not placed, pressure ulcers were not staged correctly, and dressings were not completed as ordered for a resident with chronic pressure ulcers. (Resident D) Findings include: On 9/26/24 at 11:48 A.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, paraplegia, diabetes mellitus, anxiety, and depression. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 8/23/24, indicated no cognitive impairment, extensive assistance of one with bed mobility, extensive assistance of two with toileting, total dependence of two with transfers, and two stage 4 pressure ulcers. Current physician orders included, but were not limited to: Dakins (1/4 strength) External Solution (Sodium Hydrochloride), apply to right and left ischium topically one time a day for wound healing, dated 7/24/24. Cleanse wound bed with Dakins flush and gently pack ulcers with plain packing strips, cover with bordered foam. Change daily, dated 6/6/24. Weekly skin assessments to be completed every Wednesday, dated 4/5/23. Continue protective dressing of border foam to coccyx, change three times a week on Tuesday, Friday and Sunday, dated 9/16/22. A current pressure ulcer care plan, dated 4/25/24, indicated the resident had pressure ulcers to bilateral buttocks. Interventions included, but were not limited to: Assess/record/monitor wound healing weekly, measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician, dated 6/19/24. Treatment as ordered, dated 2/7/24. Weekly skin check, dated 2/7/24. Resident D's Medication Administration Record (MAR) from June 2024 indicated wound treatment was not done on 6/3/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's MAR from July 2024 indicated the resident went to a wound clinic appointment on 7/17/24 at 11:00 A.M. Wound clinic notes from July indicated the resident went for an appointment that month on 7/24/24. The MAR also indicated a wound treatment was not done on 7/24/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date. Resident D's MAR from August 2024 indicated no treatments were performed on buttock wounds on 8/30/24 with no indication why. The MAR also indicated wound treatment was not done on 8/21/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date. Resident D's Medication Administration Record (MAR) from June 2024 through September 2024 indicated skin assessments were completed every Wednesday with a checkmark. The record lacked skin assessment documentation in June 2024. Documentation of skin assessments from July 2024 through September 2024 were not completed on Wednesdays as ordered or indicated in the MAR, and were completed on the following dates: 7/1/24 (Monday) 7/8/24 (Monday) 7/15/24 (Monday) 7/22/24 (Monday) 7/29/24 (Monday) 8/5/24 (Monday) 8/5/24 (Monday) 8/16/24 (Friday) 8/22/24 (Thursday) 8/29/24 (Thursday) 9/5/24 (Thursday) 9/13/24 (Friday) 9/20/24 (Friday) All skin assessments indicated a current loss of skin integrity, but no new loss of skin integrity. Resident D experienced the following pressure ulcers from June 2024 through September 2024: (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pressure ulcer 1: A wound clinic note, dated 6/5/24, indicated a stage 3 pressure ulcer to the left lateral buttock that was closed. Wound was identified 2/7/24. Orders placed included, but were not limited to, cleanse and fill wound space (of other two wounds) with dry plain packing strip and cover with border foam, and apply skin prep to area around those wounds. The order for skin prep was not placed or initiated at the facility. A weekly wound evaluation, dated 6/7/24, indicated a left buttock stage 3 pressure ulcer, measuring .8 cm (centimeters) x 1.1 cm x .1 cm that was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a left buttock stage 3 pressure ulcer, measuring .6 cm x .8 cm x .5 cm. A weekly wound evaluation, dated 6/21/24, indicated a left buttock stage 3 pressure ulcer, measuring 0 cm x 0 cm x 0 cm. Wound was identified 3/24/19 and healed 6/21/24. Pressure ulcer 2: A wound clinic note, dated 6/5/24, indicated a stage 4 pressure ulcer to the left buttock, measuring 1 cm x 1. 1 cm x 1.2 cm that was identified 9/16/20. At that time, a recommendation of a protective dressing of border foam over the sacrum to be changed weekly and pulled back and assessed daily was placed. An order was placed to cleanse wound beds with Dakin's flush at each dressing change, fill wound space with dry plain packing strip, and cover with border foam daily and as needed. A weekly wound evaluation, dated 6/7/24, indicated a left buttock stage 4 pressure ulcer, measuring 1.2 cm x 1.4 cm x 1 cm. Wound was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a left buttock stage 4 pressure ulcer, measuring 1.2 cm x 1.4 cm x 1 cm. A weekly wound evaluation, dated 6/21/24, indicated a left buttock stage 4 pressure ulcer, measuring 1 cm x 1.4 cm x 1.2 cm. Wound was identified 3/24/19. A wound clinic note, dated 6/26/24, indicated a stage 4 pressure ulcer to the left buttock, measuring 1 cm x 1. 4 cm x 1.2 cm. A weekly wound evaluation, dated 6/28/24, indicated a left buttock stage 4 pressure ulcer, measuring .9 cm x 1.3 cm x 1.2 cm. Wound was identified 3/26/19. A weekly wound evaluation, dated 7/5/24, indicated a left buttock stage 4 pressure ulcer, measuring 1 cm x 1. 2 cm x 1.2 cm. A wound clinic note, dated 7/24/24, indicated a stage 4 pressure ulcer to the left buttock, measuring .5 cm x . 6 cm x 1 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound clinic note, dated 8/21/24, indicated a stage 4 pressure ulcer to the left buttock, measuring .2 cm x .3 cm x .3 cm. A weekly wound evaluation, dated 8/23/24, indicated a stage 4 pressure ulcer to the left ischium, measuring .2 cm x .3 cm x .3 cm. The form indicated a treatment was ordered 8/21/23 (did not indicate what the treatment was). A wound clinic note, dated 9/11/24, indicated a stage 4 pressure ulcer to the left buttock, measuring .5 cm x .6 cm x .5 cm. The clinical record lacked wound assessments after 7/5/24. The clinical record lacked weekly wound assessments from 7/5/24 through 8/23/24, and after 8/23/24. Pressure ulcer 3: A wound clinic note, dated 6/5/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x .8 cm that was identified 9/16/20. At that time, a recommendation of a protective dressing of border foam over the sacrum to be changed weekly and pulled back and assessed daily was placed. An order was placed to cleanse wound beds with Dakin's flush at each dressing change, fill wound space with dry plain packing strip, and cover with border foam daily and as needed. A weekly wound evaluation, dated 6/7/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x .8 cm. Wound was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x 1 cm. A weekly wound evaluation, dated 6/21/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x 1 cm. Wound was identified 3/24/19. A wound clinic note, dated 6/26/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .9 cm x 1 cm x .9 cm. A weekly wound evaluation, dated 6/28/24, indicated a stage 3 pressure ulcer to the right buttock, measuring .9 cm x .9 cm x .9 cm. Wound was identified 3/26/19. A weekly wound evaluation, dated 7/5/24, indicated a stage 3 pressure ulcer to the right buttock, measuring .8 cm x .8 cm x 1 cm. A wound clinic note, dated 7/24/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .5 cm x .9 cm x .5 cm. A wound clinic note, dated 8/21/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .8 cm x .9 cm x .6 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weekly wound evaluation, dated 8/23/24, indicated a stage 4 pressure ulcer to the right ischium, measuring .8 cm x .9 cm x .6 cm. The form indicated a treatment was ordered 8/21/24 (did not indicate what the treatment was). A new treatment order was not placed on 8/21/24. A wound clinic note, dated 9/11/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x .5 cm x .5 cm. The clinical record lacked weekly wound assessments from 7/5/24 through 8/23/24, and after 8/23/24. Pressure ulcer 4: A weekly wound evaluation, dated 9/19/24, indicated a stage 1 pressure ulcer to the right buttock, measuring .5 cm x .5 cm x 0 cm was identified 9/17/24. The form indicated a new treatment to monitor; cleanse bilateral buttock, pat dry, apply skin prep to surrounding area and cover with border foam was dated 9/17/24. The new treatment order on 9/17/24 was not placed or initiated. Pressure ulcer 5: A wound evaluation, dated 9/19/24, indicated a stage 1 pressure ulcer to the left buttock, measuring 3 cm x 1.7 cm x 0 cm was identified 9/17/24. The form indicated a new treatment to monitor; cleanse bilateral buttock, pat dry, apply skin prep to surrounding area and cover with border foam was dated 9/18/24. The new treatment order on 9/18/24 was not placed or initiated. Pressure ulcer 6: A wound evaluation, dated 9/23/24, indicated an additional open area of existing wound on the left buttock measuring 2 cm x 2.5 cm x 1.5 cm was identified on 9/22/24. The wound was not staged and indicated a current treatment to cleanse the area daily with normal saline, pat dry, apply skin prep around the wound, cover with border foam, and change when soiled or dislodged, dated 9/18/24. The new treatment order on 9/18/24 was not placed or initiated. Resident D's clinical record lacked Interdisciplinary Team (IDT) meetings or notes related to the resident's pressure ulcers from June 2024 through September 2024. On 9/26/24 at 11:57 A.M., The Director of Nursing (DON) provided wound management logs for Resident D and indicated they were not part of the clinical record. The forms were hand written and included the following information: Wound log for a stage 4 pressure ulcer on the left ischium/left distal buttock, identified on 9/16/20: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24, the wound measured .2 cm x .3 cm x .3 cm. On 9/6/24, the wound measured .5 cm x .6 cm x .3 cm. On 9/13/24, the wound measured .5 cm x .6 cm x .3 cm. On 9/20/24, the wound measured 2 cm x 2.5 cm x 1.5 cm. Wound log for a stage 4 pressure ulcer on the left ischium/right buttock, identified on 9/16/20: On 8/23/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/6/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/13/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/20/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/26/24 at 2:35 P.M., the DON indicated wound assessments were not in the resident's clinical records and had not been when she started at the facility on 8/12/24, and she had started handwritten weekly wound assessments on paper beginning 8/23/24. She indicated since Resident D's areas on her buttocks had not been documented appropriately, and the areas were not separated on documentation, only one care plan was in place for pressure ulcers, although a separate care plan should be in place for each area. She indicated a quality improvement plan was needed for documentation including wound documentation. On 9/30/24 at 10:00 A.M., the DON indicated Resident D's treatment order from 9/16/22 for the bordered foam to coccyx three times a week should have been discontinued when a new order was placed for a new dressing, and had been checked off on the MAR without actually completing it because it was a current order. She indicated the right buttock pressure ulcer was mis-staged on the 6/28/24 and 7/5/24 evaluations and should have been marked as a stage 4 instead of a stage 3 pressure ulcer. She indicated wound evaluations should have been done in house weekly, and the skin assessment on 9/20/24 should have identified a new area identified on 9/17/24. The DON indicated all wound clinic orders should have been transferred to the facility, and the skin prep order should have been put in the treatment orders. She further indicated Resident D had been to the wound clinic on 7/24/24, not on 7/17/24, and should have been changed in the clinical record to reflect the correct appointment date. On 9/30/24 at 3:00 P.M., the DON indicated the facility did not have a current policy for the prevention and/or treatment of pressure ulcers or wounds, or a policy related to wound assessments. On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Comprehensive Care Plan policy that indicated The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues . The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning /CQI meetings where in-depth review of the 24 Hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Federal tag relates to Complaint IN00442764. 3.1-40(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45933 Based on observation, interview, and record review, the facility failed to provide adequate supervision and prevent falls for 1 of 2 residents reviewed for accidents. Fall risk assessments and neuro (neurological) assessments were not completed after a resident fell . The care plan was not updated after a fall. (Resident L) Findings include: On 9/25/24 at 1:46 P.M., Resident L's clinical record was reviewed. Diagnoses included, but was not limited to, unsteadiness on feet, anxiety disorder, and diabetes mellitus. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident L had severe cognitive impairment and required supervision of 1 staff member for bed mobility, and supervision and setup help for transfer and toileting. Current Physicians Orders included, but was not limited to, OLANZapine [psychotropic] Oral Tablet Disintegrating 5 MG (Olanzapine). Give 5 mg by mouth at bedtime related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXED FEATURES . dated 8/23/2024 Resident L's care plan included, but was not limited to, [Resident] is at risk for falls r/t [related to] dementia with behavioral disturbance, convulsions, unsteadiness on feet .date initiated 7/18/24 .Interventions Attempt to keep areas free of clutter Date Initiated: 7/18/24. Keep call light in reach Date Initiated 7/18/24. Move resident to a location to provide more assistance Date Initiated: 7/18/24. Notify and update MD [medical doctor] as needed Date Initiated 7/18/24. Therapy screen as indicated, quarterly and prn [as needed] Date Initiated 7/18/24. A review of Resident L's falls since admission on 7/15/24 included, but was not limited to, the following: On 7/28/24 Resident L had an unwitnessed fall in the hallway. The facility failed to complete neuro checks, update Resident L's care plan, and failed to complete a fall risk assessment. On 9/14/24 Resident L had an unwitnessed fall in the dining room. The facility failed to complete neuro checks, and the fall risk assessment lacked that Resident L received psychotropic and was completed incorrectly. During an interview on 9/26/24 at 8:57 A.M., RN (Registered Nurse) 3 indicated if a resident had an unwitnessed fall, neuro checks should be completed. During an interview on 9/27/24 at 11:19 A.M., the DON (Director of Nursing) indicated Resident L should have had a new care plan intervention and fall risk assessment completed after every fall, and the fall risk assessment on 9/14 should have indicated Resident L received psychotropic's. At that time, she indicated Resident L should have had neuro checks after the falls on 7/28 and 9/14. (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:30 P.M., the DON provided a current, undated, Baseline Care Plan Assessment/ Comprehensive Care Plans policy that indicated, .The Comprehensive Care Plans will be reviewed .more often based on changes in the resident's condition . On 9/30/24 at 12:30 P.M., the DON provided a current Guidelines for incidents/ accidents/ falls policy, dated 6/30/23 that indicated, .Neuro checks will be completed after .any unwitnessed fall .each fall needs a new care plan intervention rolled out .Residents are assessed for FALL RISK upon admission, re-admission, quarterly and when there is a change of condition to include a fall . This Federal Tag relates to Complaint IN00442764. 3.1-45(a)

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	155217	A. Building B. Wing	10/01/2024

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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. 46416 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice and a comprehensive person-centered care plan for 1 of 2 residents reviewed for respiratory care. The resident was receiving oxygen without monitoring oxygen saturation (O2 sat) levels (level of oxygen in the blood) or monitoring how often and what LPM (Liter Per Minute) of oxygen was being used by the resident. The order lacked perimeters for the staff to determine accurate LPM needed and a care plan was not developed for oxygen use. (Resident 30) Finding includes: On 9/26/24 at 11:15 A.M., Resident 30 was observed asleep in her bed wearing O2 per nasal cannula at 3 LPM. On 9/27/24 at 7:22 A.M., Resident 30 was observed eating breakfast wearing oxygen (O2) per nasal cannula at 3 LPM with the right nasal cannula on the outside of her nose. At that time, the resident indicated she wore her oxygen all the time. On 9/27/24 at 7:51 A.M., Resident 30 was observed laying in bed wearing her O2 per nasal cannula at 3 LPM and the nasal cannula was still out of her right nostril. On 9/27/24 at 12:42 P.M., RN (Registered Nurse) 5 was observed delivering a meal to Resident 30 in her room. Resident 30 had her right nasal cannula outside her right nostril and RN 5 did not bring it to Resident 30's attention or adjust the nasal cannula. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, and was on oxygen but did not specify if it was continuous or intermittent use. Current Physician's Orders included, but were not limited to, the following: O2 at 1-3 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for SOB (Shortness of Breath) as needed, ordered 9/24/2024 The clinical record lacked a care plan for oxygen use. The following were the documented O2 sats for the month of September 2024: 9/12/24 11:04 A.M. 98.0% Oxygen via Nasal Cannula 9/11/24 7:22 A.M. 90.0% Oxygen via Nasal Cannula (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/10/24 8:43 P.M. 90.0% on Room Air 9/10/24 8:10 A.M. 90.0% Oxygen via Nasal Cannula 9/9/24 10:40 A.M. 92.0% on Room Air 9/8/24 10:43 A.M. 100.0% Oxygen via Nasal Cannula 9/8/24 6:46 A.M. 92.0% Oxygen via Nasal Cannula 9/7/24 8:09 A.M. 94.0% on Room Air 9/7/24 10:02 P.M. 96.0% Oxygen via Nasal Cannula 9/6/24 9:04 P.M. 91.0% Oxygen via Nasal Cannula 9/6/24 11:56 A.M. 92.0% on Room Air 9/6/24 7:09 A.M. 91.0% on Room Air 9/5/24 11:55 P.M. 91.0% Oxygen via Nasal Cannula The clinical record lacked documentation of staff checking the resident's oxygen concentrator to make sure it was on the correct LPM. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was unsure who was putting in the orders and care plans prior to her employment (8/12/24), but there should be a care plan and an order for the staff to be checking Resident 30's O2 sats on room air at least every shift and as needed for shortness of breath, and if the resident was wearing the O2, there should be an order to monitor the LPM and O2 sats while she is on O2. In the current order for her to wear oxygen, there should be perimeters for the amount of oxygen to be administered based on her O2 sats. The DON indicated Resident 30 did not wear oxygen all the time, it was to be used as needed, and the resident was aware of that. At that time, the DON indicated Resident 30 was getting her vitals, including her O2 sat, checked once every shift but that was discontinued and she wasn't sure why. On 9/30/24 at 12:30 P.M., a current non dated Oxygen Administration Policy was provided by the DON and indicated . It is the policy of this facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered . Resident with oxygen orders, routine and PRN [as needed], will have oxygen saturation levels measured by oximetry per physician order indicating clinical oxygen saturation to be maintained. Oxygen saturation will be checked and documented every shift to meet order specifications . Residents who have oxygen orders, whether scheduled or PRN will have oxygen saturation levels measured no less than daily. If MD [Medical Doctor] order states 'to maintain sat' then oxygen saturation will be checked and documented every shift. MD will be notified whenever titration is required to maintain a saturation . 3.1-47(a)(6)

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	155217	A. Building B. Wing	10/01/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46882 Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted and contained the correct information daily for 1 of 6 days reviewed during the survey. (September 24) Findings include: On 9/24/24 at 9:14 A.M., Posted Nurse Staffing was observed hanging on the wall next to the nurse's station by the entrance dated 9/19/24. During an interview on 9/30/24 at 10:13 A.M., the DON (Director of Nursing) indicated the ADON (Assistant Director of Nursing) filled out the Posted Nurse Staffing form and checked it daily. Night shift changed the Posted Nurse Staffing form out each night. The Posted Nurse Staffing form should be current. On 9/30/24 at 12:30 P.M., DON provided an undated BIPA (Benefits Improvement and Protection Act of 2000) Staffing Posting Requirements policy which indicated 1. SNFs (Skilled Nursing Facilities) and NFs (Nursing Facilities) must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period .3. Other required posted data includes: .b) Current date .

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	155217	A. Building B. Wing	10/01/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38770 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed for Urinary Tract Infections (UTI). A resident with a UTI missed 4 of 28 ordered doses of an intravenous (IV) antibiotic. (Resident F) Finding includes: On 9/27/24 at 10:47 A.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, obstructive uropathy. The most recent Discharge MDS (Minimum Data Set) Assessment, dated 9/14/24, indicated an indwelling catheter and frequent bowel incontinence. Cognition status was not assessed. Physician orders included, but were not limited to: Cefepime HCl Infection Solution Reconstituted 1 GM (gram), use 50 ml (milliliter) intravenously every 6 hours for UTI for 7 days, reconstituted with 50 ml normal saline, dated 9/19/24 through 9/25/24. Resident F's Medication Administration Record (MAR) for September 2024 indicated Cefepime was not administered as ordered on the following dates/times: 9/19/24 at 12:00 A.M. (indicated other/see nurse notes) 9/19/24 at 6:00 A.M. (indicated other/see nurse notes) 9/20/24 at 12:00 P.M. (indicated other/see nurse notes) 9/25/24 at 12:00 P.M. (indicated other/see nurse notes) Resident F's clinical record lacked a nurse note related to why Cefepime was not administered. Resident F's clinical record lacked physician notification of the missed doses of Cefepime, or any investigation into why the medication was missed. On 9/30/24 at 9:50 A.M., the Director of Nursing (DON) indicated there should have been a nurses note in the clinical record to explain why the doses of Cefepime were not given to Resident F. The DON further indicated the physician had not been notified of the missed doses, nor had an investigation been conducted related to the missing doses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

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Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Medication Administration Errors policy that indicated Administration-based medication errors Examples include but are not limited to . Missed medication . Upon identification of a medication error the facility will . Complete medication error report form . Notify the physician and family of the medication error . Conduct an investigation regarding how the error occurred . Institute interventions to prevent further recurrence of medication error This Federal tag relates to Complaint IN00442764. 3.1-48(c)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

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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. 45933 Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 1 of 2 medication carts observed. A narcotic box was unlocked. (100/200 Hall) Findings include: During an observation on 9/24/24 at 9:38 A.M., the medication cart on the 100/200 hall was reviewed. The narcotic lock box was observed unlocked. At that time, the ADON (Assistant Director of Nursing) indicated it should have been locked. On 9/30/24 at 12:30 P.M., the DON (Director of Nursing) provided a current Medication Storage in the Facility policy, dated February 2017 that indicated, .All drugs classified as Schedule II of the Controlled Substances Act will be stored under double locks . This Federal Tag relates to Complaint IN00442764. 3.1-25(n)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

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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. 46416 Based on observation, interview, and record review, the facility failed to serve food in accordance with professional standards for food service safety for 1 of 1 observations of the kitchen. The food temperature log lacked food temperatures for food served 12 of 19 days reviewed. Finding includes: On 9/24/24 at 9:38 A.M., the food temperature logs from 9/5/24 through 9/23/24 were reviewed. The following dates had no temperatures documented for the food served at dinner: 9/6/24 9/8/24 9/10/24--no temperatures for breakfast, lunch, or dinner 9/13/24--no temperatures for breakfast, lunch, or dinner 9/15/24 9/16/24 9/17/24 9/18/24 9/20/24 9/21/24 9/22/24 9/23/24 On 9/24/24 at 9:40 A.M., the Dietary Manager indicated if there was nothing written for food served at dinner on those days, staff probably didn't do them. If they were taken, they should be documented there. At that time, he indicated they do have some newer staff at that time and they may need to re-educate them about getting food temperatures before serving it. (continued on next page)

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	155217	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:30 P.M., a current non dated Monitoring Food Temperatures Policy was provided by the DON (Director of Nursing) and indicated, .food temperatures will be monitored daily to prevent food borne illness. Food temperatures will be taken and recorded for all hot and cold foods prior to placing them on the serving line. The temperature for each food item shall be recorded on the Food Temperature Log . If hot foods are not 135 degrees Fahrenheit or higher when checked, they will be reheated to at least 135 degrees Fahrenheit. Cold foods and beverages which are not 41 degrees Fahrenheit or below will be chilled on ice or in the freezer . 3.1-21(i)(2) 3.1-21(i)(3)

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	155217	A. Building B. Wing	10/01/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45933 Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection during 1 of 4 observations of care. The facility failed to track all infections for 3 of 5 residents reviewed for infections. Staff lathered hands for 6 seconds, touched items with gloved hands before care was performed, wiped the residents buttock's first, failed to perform hand hygiene when gloves were changed, and touched multiple items with soiled gloves after care. (Resident G, Resident J, Resident K, Resident M) Findings include: 1. On 10/1/24 at 9:15 A.M., the facility tracking binder was reviewed for July 2024, August 2024, and September 2024. The facility tracking lacked the following UTI's (urinary tract infections): Resident K had a UTI in July 2024. The facility tracking map lacked documentation of the UTI. Resident J had a UTI in August 2024. The facility tracking map lacked documentation of the UTI. Resident G had a UTI in August and September 2024. The facility tracking map lacked documentation of the UTI. During an interview on 10/1/24 at 9:23 A.M., the IP (Infection Preventionist) indicated the UTI's were not tracked due to her not being able to complete them. The facility tracking should have had their name, date, infection, and be labeled on the facility tracking map. 46416 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 9/27/24 at 10:47 A.M., CNA (Certified Nurse Aide) 7 and RN (Registered Nurse) 5 were observed performing incontinence care on Resident M. CNA 7 washed her hands with a 13 second lather of soap and RN 5 with a 6 second lather. Both put on gloves and RN 5 hooked the strap of the lift pad on to the lift. CNA 7 removed the resident's blanket, hooked the other straps of the lift pad on to the lift, used the controller to raise the resident from her wheelchair, and lower her into the bed. CNA 7 opened the closet door, grabbed a clean incontinence pad, and closed the closet. CNA 7 opened the dresser, grabbed wipes, and closed the drawers. CNA 7 did not remove gloves or perform hand hygiene prior to beginning incontinence care. They rolled Resident M onto her right side and RN 5 tucked the soiled incontinence pad under the resident. CNA 7 grabbed a wipe from the package laying on the blanket, and reached across the resident to wipe Resident M's left hip, grabbed another wipe and wiped left hip area again, while RN 5 tucked a new incontinence pad under the resident using her gloved hands on the inside and center of the clean incontinence pad. Resident M was rolled on to her left side. CNA 7 pulled out the soiled incontinence pad. CNA 7 grabbed a wipe and wiped the resident's backside from front to back with bowel movement visible on her gloves. She grabbed another wipe, and wiped bowel movement off her gloves with the wipe. CNA 7 propped herself by leaning on her left hand glove in a fist on the clean sheet. After grabbing 3 more wipes and wiping the resident, CNA 7 removed her gloves, discarded them, and put on new gloves without using hand hygiene. At that time, the resident indicated she was urinating. Someone knocked on the door, proceeded to open door with the resident exposed, then closed the door. Then opened the door again and threw a clean dress on a hanger on to residents feet and closed the door again. CNA 7 indicated the resident's urine did not get on the clean incontinence pad so they continued care. Resident M was rolled to the left side again while CNA pulled the new incontinence pad out and then rolled the resident to her back. CNA 7 wiped the resident's perineal (peri) area crease on the left, got a new wipe, and folded and wiped 3 times from front to back. CNA 7 lifted the resident's dress out of the way wearing the same gloves and both CNA 7 and RN 5 fastened the incontinence pad with their gloves on. CNA 7 opened the dresser drawer, put the wipes in a drawer, then closed it. CNA 7 grabbed the clean dress off the bed, opened the closet, hung the clean dress in the closet, and closed the closet. CNA 7 then used the controller to lower the bed to floor, and took off her gloves. She held on to her soiled gloves and touched those gloves to her left side scrub pocket to get a trash can liner from her pocket. RN 5 washed her hands with a 9 second lather with soap and then CNA 7 washed her hands with an 8 second lather. During an interview on 10/1/24 at 9:00 A.M., the Infection Preventionist (IP) indicated she would expect staff to clean the resident's front side, take off gloves, wash hands, put new gloves on, clean the resident's back side, and then remove gloves and wash hands. While washing their hands, staff should lather with soap for at least 20 seconds, should change gloves and wash hands if they touch items, they definitely should sanitize hands and change gloves between clean and dirty tasks, and should change gloves and sanitize hands after care was completed before they touch any other items. On 9/30/24 at 3:14 P.M., a current Perineal Care Policy, dated 4/12/23, was provided by the Director of Nursing (DON) and indicated . separate the labia and clean downward from front to back . turn the resident to the side . clean the rectal area . On 9/30/24 at 3:14 P.M., a current Guidelines for Gloves Policy, dated 4/12/23, was provided by the DON and indicated . Procedure: perform hand hygiene apply latex free non-sterile gloves one at a time . remove gloves . perform hand hygiene . if for any reason there is a need to remove the gloves and reapply new gloves, hand hygiene must occur between the removal of the used pair of gloves and the application of the new pair of gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 3:14 P.M., a current non dated Hand Hygiene Policy was provided by the DON, and indicated . hands should be washed with a non-microbial or anti-microbial soap . apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds . On 10/1/24 at 9:32 A.M., the IP provided a current Guidelines for infection Prevention and Control policy, dated 8/17/23 that indicated, .A surveillance system designed to do the following will be maintained: Identify possible communicable diseases or infections before they can spread to other persons in the facility .A recording system for incidents under the facility's INFECTION AND PREVENTION and CONTROL PROGRAM to do the following will be maintained: Identify any incident(s) considered as an infection risk within the facility . This Federal tag relates to Complaint IN00443360. 3.1-18(b)(1) 3.1-18(l)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on interview and record review, the facility failed to administer or properly document the pneumococcal immunization for 3 of 5 residents reviewed for immunizations. Clinical records lacked documentation that the resident received or refused a pneumococcal vaccine when a consent was signed to receive the vaccine. (Resident 20, Resident 5, Resident 4) Findings include: 1. On 9/30/24 at 9:17 A.M., Resident 20's clinical record was reviewed. Diagnosis included, but was not limited to schizoaffective disorder, hypertension, diabetes mellitus, hyperlipidemia, aphasia, non-Alzheimer's dementia, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 20 was severely cognitively impaired and his pneumococcal vaccine was not up to date. Resident 20 was [AGE] years old and was admitted on [DATE]. Resident 20's immunization record was reviewed for pneumococcal vaccine. Resident 20 received Prevnar-13 on 12/20/2022. The clinical record lacked documentation that the second dose of the pneumococcal vaccine was offered, administered, or refused since that time. During an interview on 9/30/24 at 12:32 P.M., DON (Director of Nursing) indicated Resident 20 should have had a second pneumococcal vaccine. 2. On 9/30/24 at 9:17 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to COPD (Chronic obstructive pulmonary disease), hypertension, fracture, depression, and asthma. The most recent Quarterly MDS Assessment, dated 8/1/24, indicated Resident 5 had moderate cognitive impairment and her pneumococcal vaccine was not up to date. Resident 5 was 85 and was admitted on [DATE]. Resident 5's immunization record was reviewed for pneumococcal vaccine. The most recent consent form for the pneumococcal vaccine was signed on 8/3/22. The clinical record lacked documentation that the pneumococcal vaccine was offered, ordered, administered, or refused since that time. 3. On 9/26/24 at 11:50 A.M., Resident 4's clinical record was reviewed. Diagnosis included, but was not limited to abscess of lung without pneumonia, asthma, diabetes mellitus with diabetic neuropathy, COPD, and dementia. The most recent Quarterly MDS assessment, dated 9/15/24, indicated Resident 4 was cognitively intact and her pneumococcal vaccine was not up to date. Resident 4 was 88 and admitted on [DATE]. Resident 4's immunization record was reviewed for pneumococcal vaccine. The most recent consent form was signed on 5/27/23 to receive the pneumococcal vaccine. The clinical record lacked documentation that the pneumococcal vaccine was ordered, administered, or refused. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/24 at 2:42 P.M., DON (Director of Nursing) indicated if residents have a signed consent form they should receive the vaccine. On 9/24/24 at 11:15 A.M., the Administrator provided an undated Guidelines for Pneumococcal Vaccination policy which indicated It is the intent of the facility to minimize the risk of residents acquiring, transmitting, and /or experiencing complications from Pneumococcal pneumonia. This policy will assure that each resident and/or the Representative/(POA)[Power of Attorney] is informed about the benefits and risks of immunization related to Pneumococcal pneumonia and that each resident has the opportunity to receive the vaccine unless medically contraindicated or refused- or the resident has already been immunized with the vaccine. The resident's (facility) medical record will contain documentation as to the information/education provided to the resident and/or their Representative/(POA) regarding the risks and benefits of this immunization as well as the administration or the refusal of the vaccine, or the medical contraindication to the vaccine done by the facility. 3.1-13(a)