

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Waters of Covington, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E Liberty St Covington, IN 47932	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on interview and record review, the facility failed to notify a resident's representative of changes in condition and treatment for 1 of 3 residents reviewed for family and /or representative notification. (Resident B)</p> <p>Findings include:</p> <p>On 11/22/24 at 10:00 a.m., during a phone interview, the Power of Attorney (POA) of Resident B indicated she had not been notified of changes in the condition of the resident including an incident which occurred between Resident B and another resident, or that the resident was to be sent to a psychiatric facility. Resident B was on hospice services and the hospice agency had not been informed of an order to transfer the resident. She indicated she had not been notified of medication changes such as a treatment for a rash or that the resident had been placed in isolation.</p> <p>On 11/22/24 at 10:30 a.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. The most recent re-admission was on 1/13/24. Admission diagnosis included but were not limited to chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) with other behavioral disturbance, chronic heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), anxiety disorder (a feeling of fear, dread, and uneasiness).</p> <p>Physician orders included, but were not limited to, Sertraline (antidepressant) oral tablet 100 milligrams (mg) 1 tablet by mouth in the morning for depression, xanax (antianxiety) oral tablet 0.5 mg 1 tablet in the evening for anxiety, alprazolam (antianxiety) tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for anxiety</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was not cognitively intact and required extensive assistance of two persons for care.</p> <p>A care plan, dated 6/4/22, indicated the resident received anti-anxiety medications and was at risk for side effects related to diagnosis of anxiety and nervousness. Interventions included but were not limited to administer medications per physician orders, provide TLC (tender loving care), reassure resident as needed, redirect resident as needed.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse progress notes, dated 10/30/2024 at 7:09 p.m., indicated an incident had occurred between Resident B and another resident. The residents were separated and Resident B continued to be agitated. The staff stayed one on one with Resident B so the nurse could contact the doctor for further orders.</p> <p>On 10/30/24 at 7:47 p.m., the medical record indicated the physician was notified and an order was obtained to transfer the resident to a psychiatric facility for evaluation. The record lacked documentation of POA or hospice notification of the incident or the transfer the psychiatric facility.</p> <p>The medical record indicated on 9/12/24 a chest x-ray was administered to Resident B and on 9/13/24 the resident was placed on an antibiotic. The record lacked documentation of POA notification of medication order or change in condition.</p> <p>On 9/23/24 the medical record indicated a change in condition and the resident was administered intravenous fluids (fluids administered through a vein). The record lacked documentation of POA notification.</p> <p>On 10/4/24 the medical record indicated the resident had a change in condition and was sent to the hospital emergency room (ER) for evaluation and treatment. The record lacked documentation of POA notification</p> <p>On 11/22/24 at 12:25 p.m., during an interview, Qualified Medication Aide (QMA) 3 indicated if a resident had a change in condition they would notify the nurse, and the nurse would call the physician and the family.</p> <p>On 11/22/24 at 1:27 p.m., during an interview, Registered Nurse (RN) 4 indicated if a resident had a change of condition the RN would notify the family and document the notification in the assessment and in the nurses notes. If the nurse needed to send a resident out to the hospital the nurse would call an ambulance first then call the family. The RN indicated if a resident was on hospice services the nurse would contact the hospice nurse first and await directives from the hospice nurse and physician.</p> <p>On 11/22/24 at 1:35 p.m., during an interview, the Director of Nursing (DON) indicated if there was a change of condition in a resident the nurse should notify the family or responsible party first and notify them they had an order to send the resident to the hospital. She indicated if there was a change in medication the family or POA should be notified.</p> <p>On 11/22/2024 at 1:54 p.m., the DON provided an undated document titled, Your Rights and Protections as a Nursing Home Resident, and indicated it was the policy currently being used by the facility. The policy indicated, .Have Your Representative Notified: The nursing home must notify your doctor and, if known, your legal representative .when the following occurs: Your physical, mental, or psychological status starts to get worse .The nursing home decides to transfer or discharge you from the nursing home</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/22/2024 at 1:55 p.m., the DON provided an undated document titled, Change in Resident's Condition Status, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status .Procedure .2. Unless otherwise instructed the resident (if the resident is alert and oriented and their own representative) the nurse will notify the resident's representative when .Abuse situations or allegations of abuse. There is significant change in the resident's physical, mental or psychosocial status .A decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to the hospital</p> <p>This citation relates to Complaint IN00446280.</p> <p>3.1-5(a)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>35317</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL) (daily self-care activities) received assistance with removal of facial hairs for 3 of 3 residents reviewed for facial hair (Residents E, F, and G), failed to clean and cut finger nails for 1 of 4 residents reviewed for ADL care (Resident B), and the facility failed to ensure a resident was provided showers for 1 of 3 residents reviewed for showers (Resident D).</p> <p>Findings include:</p> <p>1. During an observation, on 11/22/24 at 12:00 p.m., Resident B was observed seated at a table in the dining room with long, jagged nails, that contained dark debris underneath them.</p> <p>Resident B's record was reviewed, on 11/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident had severe cognitive impairment and required extensive assistance of two persons for care.</p> <p>A care plan, dated 6/4/22, indicated the resident received antianxiety medications. Interventions included, but were not limited to, the resident will have all needs met throughout the day being clean and odor free, all ADLs provided daily.</p> <p>2. During an observation, on 11/22/24 at 12:00 p.m., Resident E was observed seated at a table in the dining room with multiple chin hairs.</p> <p>Resident E's record was reviewed, on 11/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/24, indicated the resident was cognitively intact and required extensive assistance of one person for bed mobility, transfers, toileting, personal hygiene, and bathing.</p> <p>A care plan, dated 11/26/21, indicated the resident required assistance with ADLs due to poor activity endurance with interventions included, but were not limited to, encourage the resident to complete as much as they are able, and resident will perform ADLs with limited assistance by discharge to home.</p> <p>3. During an observation, on 11/22/24 at 12:00 p.m., Resident F was observed seated at a table in the dining room with multiple chin hairs.</p> <p>Resident F's record was reviewed, on 11/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident had severe cognitive impairment and required extensive assistance of two persons for bed mobility, transfers, toileting, personal hygiene, and bathing.</p> <p>A care plan, dated 8/23/24, indicated the resident required assistance with ADLs due to poor activity endurance with interventions included, but were not limited to, encourage the resident to complete as much as they are able, and set up and assist with shower 2 times per week and as needed.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an observation, on 11/22/24 at 12:00 p.m., Resident G was observed seated at a table in the dining room with multiple chin hairs.</p> <p>Resident G's record was reviewed, on 11/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident had severe cognitive impairment and required extensive assistance of one person for bed mobility, transfers, toileting, personal hygiene, and bathing.</p> <p>A care plan, dated 3/29/24, indicated the resident required assistance with ADLs related to diagnosis of reduced mobility, lack of coordination, schizophrenia (a serious mental condition that affects the way a person, thinks, acts and feels) with interventions included, but were not limited to, encourage the resident to complete as much as they are able, and bathe per resident preference 2 times per week and as needed.</p> <p>5. During a review of a grievance form, dated 10/31/24, Resident D's family member had concerns about his showers and if his feet were being washed and dried properly. The form lacked documentation that staff were questioned about the showers.</p> <p>Resident D's record was reviewed, on 11/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 9/24/24, indicated the resident had severe cognitive impairment and required extensive assistance of two persons for bed mobility, transfers, toileting, personal hygiene, and bathing.</p> <p>A care plan, dated 09/2023, indicated the resident required assistance with ADLs due to poor activity endurance with interventions included, but were not limited to, bathe per resident preference two times per week and as needed, set up and assist with shower two times per week and as needed, and refer to most current Choices for Resident Care document for resident preferences.</p> <p>A choices for resident care form, dated 9/25/23, indicated Resident D preferred showers twice a week.</p> <p>Review of an activity resident interview, dated 9/24/24, indicated Resident D's family member found it to be very important for him to be able to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of point of care documentation, dated October 25, 2024, to November 22, 2024, indicated Resident D received three showers. The showers were documented for October 25th, November 4th, and November 10th. The record lacked any other showers documented for the last 30 days.</p> <p>During an interview, on 11/22/24 at 11:59 a.m., the Director of Nursing (DON) indicated she was not aware of anyone complaining about not getting their showers as preferred, but she was aware the Administrator was looking into using shower sheets again and binders for the Certified Nursing Aides (CNA).</p> <p>During an interview, on 11/22/24 at 12:10 p.m., Qualified Medication Aide (QMA) 3 indicated Resident D was on the evening shift shower schedule and required a Hoyer (mechanical) lift for transfers.</p> <p>During an interview, on 11/22/24 at 1:24 p.m., the DON indicated she was unable to find further documentation that Resident D had received more showers than the three that were documented in the last 30 days. She was unable to find an updated choices for resident care form since September of 2023.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a confidential interview, on 11/22/24 at 2:00 p.m., they indicated they had to shave Resident D yesterday 11/21/24 because it had been over a week since he was last shaved by the staff. There had been times when they had visited, and the resident's face and behind his ears were not clean and his feet were dry. They had questioned if he was being cleaned properly on his shower days.</p> <p>During an interview, on 11/22/24 at 12:25 p.m., Qualified Medication Aide (QMA) 5 indicated the staff would shave residents after showers which are two to three times per week. They would also clean and cut nails on shower days.</p> <p>During an interview, on 11/22/24 at 1:35 p.m., the Director of Nursing (DON) indicated staff should shave the residents and cut their nails on the residents' shower days. She further indicated if a resident was alert and oriented and had a preference not to be shaved it would be in the care plan.</p> <p>On 11/22/24 at 1:54 p.m., the DON provided an undated document titled, Activities of Daily Living, and indicated it was the policy currently being used by the facility. The policy indicated, .ADL care is provided throughout the day, evening and night as care planned and/ or as needed .Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care (as indicated and as per care plan) .Do all required ADL documentation as required per policy and regulations</p> <p>This citation relates to Complaint IN00446843.</p> <p>3.1-38(a)(3)</p>		