STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Muncie, The	2400 Chateau Dr Muncie, IN 47303

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to review and implement the hospice provider's plan of care resulting in a resident receiving Cardiopulmonary Resuscitation efforts for a resident who had signed a Do Not Resuscitate Directive for 1 of 3 resident reviewed for death. (Resident E) Findings include: Resident E's closed clinical record was reviewed on [DATE] at 11:48 a.m. Diagnoses included nontraumatic intracerebral hemorrhage/stroke, muscle wasting and atrophy, and dysphagia. The resident was admitted to hospice services on [DATE] at 6:59 p.m. A signed physician's order, dated [DATE], indicated the resident was a Full Code (CPR was to be initiated as appropriate). A signed physician's order, dated [DATE], indicated hospice was to evaluate and treat. A health care plan, dated [DATE], indicated the resident had elected a Full Code status. The care plan and interventions had no review or revised dates. A health care plan, dated [DATE], indicated the resident received hospice services. The goal indicated the resident's wishes for hospice services would be respected. Interventions included hospice services as order. A review of the resident's hospice documentation on [DATE] at 11:48 a.m., indicated the plan of care and hospice certification form were completed [DATE]. The plan of care indicated the resident's advanced directive/code status as do not resuscitate. An email sent to the facility Administrator, dated [DATE] at 10:29 a.m., provided by the hospice provider, included a POST (Physician Orders for Scope of Treatment) form attachment. The form indicated Do Not Attempt Resuscitation/DNR as the resident's code status. A nursing progress note, dated [DATE] at 8:15 a.m., indicated LPN 4 had entered the resident's room to delivery her breakfast tray. She observed the resident was not responding to verbal or tactile stimuli. She immediately left the room and checked the resident's code status in the electronic health record. The resident's clinical record indicated the resident was a full code. LPN 4 called for staff assistance and initiated cardiopulmonary resuscitation (CPR). (continued on next page)

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated [DATE] at 8:20 a.m., indicated Emergency Medical Technicians, Paramedics and the Fire Department arrived and took over resuscitation efforts. A nursing progress note, dated [DATE] at 8:40 a.m., indicated cardiopulmonary resuscitation was discontinued and the resident was declared deceased . During an interview on [DATE] at 3:39 p.m., LPN 4 indicated, when she entered Resident E's room (on [DATE]), she observed the resident positioned on her back with her head facing the window. She noticed her skin color was more pale than her usual. Her skin was cool to the touch. She was not familiar with the resident and checked her code status and noted she was a full code. She began chest compressions and alerted staff. She was aware the resident was admitted to hospice, but she had known hospice residents to be a full code before. Other staff mentioned they believed the resident was a DNR and it had been discussed previously in October. All the information she observed in the resident's electronic health record indicated the resident was a full code, so she continued CPR until another staff member took over. During an interview on [DATE] at 9:31 a.m., SSD indicated she received a call from the MDS Coordinator on [DATE] requesting any clarification on the resident's code status. She indicated she had no clarification and would need to look it up when she arrived at the facility. She called the hospice provider when she arrived at the facility and was able to obtain a faxed copy of the resident's POST form indicating the resident was a DNR. She indicated she had not reviewed the resident's hospice admission paperwork or plan of care. She should have reviewed the documentation in order to coordinate the resident's plan of care with the facilities plan of care. She felt the lack of review of the hospice clinical documentation lead to the confusion and the resident receiving CPR. During an interview on [DATE] at 10:22 a.m., the MDS Coordinator indicated compressions had already begun when she arrived at the resident's room. She had called the SSD to clarify the resident's code status when the resident was receiving hospice services. The SSD called the hospice provider when she arrived at the facility and the provider indicated they had a DNR on file. The EMS personnel discontinued CPR when the POST form, faxed by the hospice provider, was received. During a telephone interview on [DATE] at 3:38 p.m., the Director of Health Hospice indicated an electronic copy of the POST form and admission documentation was emailed to the facility administrator on [DATE]. A current facility policy, dated [DATE], titled, Guidelines for Palliative Care-Hospice Care, provided by the Administrator on [DATE] at 3:21 p.m., included the following: Key Elements of Maintain Compliance regarding Hospice .4) There must be a designated member of the facility's IDT (Interdisciplinary Team) who is responsible for working with hospice representatives to coordinate care to the resident(s) provided by the facility staff and the hospice staff. 5) Ensure that each resident's written plan of care includes both the most recent hospice plan of care as well as a description of the services provided by the LTC facility to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being This citation relates to Complaint IN00455065.