STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00417020, IN00417230, IN00417344 and IN00417901. Complaint IN00417020 - No deficiencies related to the allegations are cited. Complaint IN00417230 - Federal/State deficiencies related to the allegations are cited at F609 and F689. Complaint IN00417344 - No deficiencies related to the allegations are cited. Complaint IN00417901 - No deficiencies related to the allegation is cited. Survey dates: September 25 and 26, 2023 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 2 Medicaid: 47 Other: 16 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 1, 2023.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hewitt	Administrator	10/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility management failed to report incidents to the Indiana Department of Health when a resident (Resident F) exited the facility grounds, without supervision, and when a staff member reported an allegation of abuse (Resident C) for 2 of 3 residents reviewed for reportable incidents.	F 0609	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this	10/20/2023

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	Findings include: 1. The clinical record for Resident F was reviewed on 9/25/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance and cognitive communication deficit. The annual MDS (Minimum Data Set) assessment, dated 8/13/23, indicated the resident's cognition was moderate impaired. The progress note, dated 9/4/23 at 1:20 p.m., indicated Staff Member 2 informed Staff Member 3 that Resident F was seen walking south on the highway towards a liquor store. The police were notified of a resident that had eloped from the facility. Staff Member 2 left the facility to find the resident. The resident was cooperative and brought back to the facility by the police. The resident was assessed and offered fluids. A wander guard was placed on the residents' right wrist. Review of the State reportable's lacked documentation of the incident on 9/4/23. During an interview on 9/25/23 at 3:12 p.m., the Director of Nursing indicated she did not report incidents, but was told it was not reported because the resident's BIMS (brief interview of mental status) was high enough. The resident's BIMS prior to the elopement was moderately impaired, the resident's BIMS upon return from the elopement , on 9/4/23, was assessed to be alert and oriented by the facility. On 9/25/23 at 3:48 p.m., the Director of Nursing provided a current, undated copy of the document titled "Policy and Procedure Regarding Missing		statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 18th, 2023. This provider respectfully requests that this 2567 Plan of correction be considered the Letter of Credible Allegation of Compliance and requests desk review in lieu of a post survey review on or after October 18th, 2023. F609 It is the policy of this facility to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. Corrective action for residents affected: Resident F and C's incidents was reported in the ISDH Gateway on 10/16/2023. How other residents of the facility were identified to potentially be affected by the practices are: All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. The facility has taken the following	

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	Residents and Elopement". It included, but was not limited to, "Each state reporting guidelines related to elopement will be followed. The reporting guidelines are as follows...Indiana...Elopement of a Resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose return involves Law Enforcement...." 2. The clinical record for Resident C was reviewed on 9/25/23 at 5:06 p.m. The diagnoses included, but were not limited to, psychosis, psychotic disorder with delusions, paranoid personality disorder, and anxiety. During a confidential interview from 9/25/23 to 9/26/23, Staff Member 7 indicated, on 9/4/23, Staff Member 8 gave Resident C an Ativan that belonged to Staff Member 9. She did not witness it, but Staff Member 8 told her they gave it because Resident C was wild and off the chain. She wrote a statement and gave it the Executive Director and Director of Nursing. During a confidential interview from 9/25/23 to 9/26/23, Staff Member 10 indicated a conversation was overheard between Staff Member 8 and Staff Member 9 on 9/4/23 about giving Resident C Lorazepam (Ativan). Staff Member 9 carried her personal medications with her. Staff Member 8 told Staff Member 9 to give Resident C one of her Ativan's. She did not witness anyone to have given the resident any medication. During an interview on 9/25/23 at 5:30 p.m., the Director of Nursing indicated Staff Member 7 called her extremely upset. Staff Member 7 reported Resident C had been wild and said she was pretty sure the the resident received an		measures to ensure that the problem has been corrected and will not recur by: The RDO in-serviced the Administrator on Reporting Guidelines related to abuse, neglect, misappropriation and elopement on 10/2/2023. The Administrator/Designee in-serviced staff on the following policies: Elopement Policy; Reporting of Alleged Violations and Abuse by 10/20/2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the facility will monitor system: The ADM/designee will audit progress notes daily 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once week for months for any occurrence that requires reporting to ISDH." Any concerns noted will be immediately addressed and corrected. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be	

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	Ativan the belonged to Staff Member 9. From there, the Director of Nursing notified the Executive Director to investigate. Review of the State reportable's lacked documentation of the alleged incident on 9/4/23. On 9/25/23 at 3:48 p.m., the Director of Nursing provided a current, undated copy of the document titled "Accident Incident Reporting Policy". It included, but was not limited to, "Purpose...To ensure that...incidents that occur with residents are identified, reported, investigated, and resolved...A more extensive investigation procedure is required for the following...alleged abuse...." This Federal tag relates to Complaint IN00417230 3-1.28(c)		monitored by the Administrator weekly until resolved.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision was in place when a resident (Resident F), with impaired cognition, did not exit the facility grounds and ambulated down the highway six tenths of a mile, without supervision, for 1 of 3 residents reviewed for	F 0689	It is the policy of this facility to provide adequate supervision of its residents. Corrective action for residents affected: Residents F was assessed by the nurse and no negative outcome	10/20/2023

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	accidents/supervision. Findings include: On 9/25/23 at 2:36 p.m., Resident F was observed in the dining room participating in an activity. He had a wander guard to his right wrist. The clinical record for Resident F was reviewed on 9/25/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance and cognitive communication deficit. The annual MDS (Minimum Data Set) assessment, dated 8/13/23, indicated the resident's cognition was moderate impaired. The care plan, dated 10/18/23, indicated the Care plan date was 10/18/22, Resident F's history included, but was not limited to, impaired cognition, poor insight and lack of awareness. The elopement assessment, dated 7/26/23, indicated the resident was not at risk for elopement. The progress note, dated 9/4/23 at 1:20 p.m., indicated Resident F had been seen several times sitting outside in the front parking lot with another resident. Staff Member 2 informed Staff Member 3 that Resident F was seen walking south on the road towards a liquor store. The police were notified of a resident that had eloped from the facility. Staff Member 2 left the facility to find the resident. The resident was cooperative and brought back to the facility by the police. The resident was assessed and offered fluids. A wander guard was placed on the residents' right wrist. The physician's order, dated 9/5/23, indicated the		noted on 9/4/23. Resident F's Elopement assessment, physician order for Leave of Absence. BIMS, and care plan were updated on 10/17/23. How other residents of the facility were identified to potentially be affected by the practices are: All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: The ADM/Designee in-serviced staff on the Elopement policy, supervision on 10/16/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicted. How the facility will monitor system: The ADM/designee will interview 10 random staff members weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members weekly x 4 months on the Elopement policy, what to do for missing residents and residents with Leave of Absence orders and supervision. Any concerns noted will be immediately addressed and corrected. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be	

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	resident was to have a wander guard and to check placement and function every shift. During a confidential interview from 9/25/23 to 9/26/23, Staff Member 2 indicated management allowed the resident to sit out front and sunbathe. On 9/4/23, it was believed the resident was out on the porch sunbathing, which he did after lunch (between 11:40 a.m. and 12:30 p.m.). Staff Member 2 reported she saw the resident ambulating south on the highway heading in the direction of the liquor store. Staff Member 3 and Staff Member 4 exited the facility to look for the resident. The resident was found sitting on the front porch of a business. He was red and sweating. The police came and took him back to the facility. Staff Member 2 was unaware the resident had left the facility grounds. During a confidential interview from 9/25/23 to 9/26/23, Staff Member 3 came to facility right around 1:30 p.m. to drop off pizza, Within 2 minutes, Staff Member 2 reported that the resident was walking down the highway. It was almost 100 degrees outside. Staff Member 4 and Staff Member 3 left and found the resident sitting on the steps on a business. He was sweating pretty bad as it was hot. He rode back to the facility with the police and they put a wander guard on him. He had to have been off the property at least 30 minutes, maybe longer to get that far because he walks very slowly. During a confidential interview from 9/25/23 to 9/26/23, Staff Member 2 indicated on 9/4/23, she saw Resident F walking on the side of the road toward the liquor store. He was walking on the road because there were no sidewalks. Staff Member 2 came straight to the facility and reported to Staff Member 7 and Staff Member 2.		stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	They thought he was sitting out front sun bathing and were unaware that he was off the property. On 9/25/23 at 3:48 p.m., the Director of Nursing provided a current, undated copy of the document titled "Policy and Procedure Regarding Missing Residents and Elopement". It included, but was not limited to, "It is the policy of this facility that all residents are provided adequate supervision...." This Federal tag relates to Complaint IN00417230 3.1-45(a)(2)			