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	04/05/2022

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 IN00376272 and IN00376152. Complaint IN00376272 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00376152 - Unsubstantiated due to lack of evidence. Survey date: April 5, 2022 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare:8 Medicaid: 41 Other: 16 Total: 65 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 7, 2022.	F 0000		
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			

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

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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	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 appropriate fall interventions were identified and implemented for 1 of 3 residents reviewed for accidents. (Resident D) Findings include: During an observation, on 4/5/22 at 9:10 a.m., Resident D was lying abed. Her bed was positioned with the right side against the wall. She had an enabler bar to the right side, but not to the left side of the bed, which was open to the room. A scoop mattress was in place. Her bedside table was across her lap. She was leaning to the right side, with her left arm halfway off the bed. She had a small fading bruise on her left cheek and some scattered faded bruising to her left lower arm. During an observation, on 4/5/22 at 11:12 a.m., Resident D was resting abed, she was leaning to the right, with her left arm hanging off the mattress. Her head was on the very edge of the mattress. During an observation, on 4/5/22 at 11:46 a.m., Resident D was resting abed. She was leaning to the right; her left arm was off of the mattress as she was trying to drink with her right arm. Her head was on the far-left edge of the mattress. During an observation on 4/5/22 at 12:19 p.m., Resident D was resting abed, she had been repositioned to a sitting position, and was closer	F 0689	Preparation and/or execution of this plan of correction is general, or this corrective action does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this 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 April 21, 2022. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after April 26, 2022. F689 1) Resident D's falls were reviewed by IDT team on 4/21/22; Root Cause Analysis determined. IDT review completed, thus far, current interventions are effective. (For future reference the intradisciplinary team consists of three or more of the following disciplines: Administrator, Director of Nursing, Assistant Director of	04/26/2022

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	to the middle of the bed. A pillow had been placed under her left arm. The clinical record for Resident D was reviewed on 4/5/22 at 10:30 a.m. Diagnoses included, but were not limited to, cerebral infarction, unspecified dementia, lack of coordination, cognitive communication deficit, aphasia, weakness, difficulty walking, osteoarthritis, chronic atrial fibrillation, functional urinary incontinence, presence of cardiac pacemaker, malignant neoplasm of brain, history of COVID-19, diarrhea, urgency of urination, fatigue, headache, and hypertension. The Quarterly MDS (Minimum Data Set) assessment, dated 1/29/22, indicated the resident was moderately cognitively impaired, and required extensive assistance of two or more staff members with bed mobility. The care plan, dated 12/28/22, indicated the resident was at risk for falls due to a history of falls or recent falls. The interventions included, but were not limited to, staff to offer toileting more frequently, (4/6/21), assist resident up in wheelchair for all meals (3/18/22), tilt wheelchair (2/22/22), attempt to keep areas free of clutter (12/28/20), gripper socks while in bed (4/4/21), keep call light in reach 12/28/20), night shift to offer to assist resident to get dressed for day with both shoes on (4/21/21), notify and update physician as needed (12/28/20), rounding to include offering toileting (6/1/21), scoop mattress (10/7/21), staff to ensure bed is made timely (4/3/21), therapy screen as indicated, quarterly, and as needed (12/28/20). The nurse's note, dated 2/19/22 at 4:10 p.m., indicated the resident had fallen. When the nurse		Nursing, Staff Development Coordinator, MDS Coordinator, Dietary Manager, Business Office Manager, Activities Director, Housekeeping Supervisor, Therapist, Social Services, Certified staff, and/or licensed nursing staff). 2) On 4/18/22 residents residing in the facility that have fallen in the last 30 days were identified by the Director of Nursing. On 4/18/22-4/21/22, the identified residents were reviewed by the Intradisciplinary Team to validate fall risk assessments, fall care plans, Root Cause analysis and pain assessments were completed as indicated at the time of the event. Any discrepancies identified were reviewed by the IDT team and recommendations were implemented at the time of the review. Care plans were reviewed and revised as indicated. 3) On 4/18/22, the Administrator and Director of Nursing reviewed the procedure for "Accidents/Incident Reporting" and found the policy to be acceptable. Falls will be reviewed daily during the morning CQI meeting Monday through Friday. The IDT team will review each event to validate that the change of condition, pain assessment, neuro checks, fall assessment are completed per protocol; preventative measures implemented, 72-hour nursing documentation post event, care	

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	arrived to the scene the resident was lying on the floor, on her left side, with a pool of blood under her head. The resident was sent to the hospital for treatment. The nurse's note, dated 2/19/22 at 6:25 p.m. indicated the resident returned to the facility with 5 sutures in place to a laceration to her right forehead, and bruising to her right hand. The incident report, dated 2/19/22, indicated the resident was sitting in her wheelchair waiting to go to the dining room for dinner, staff heard a noise and found the resident lying on the floor in front of her wheelchair. The resident was assessed and sent to the hospital. She had obtained 5 sutures. The preventative measures included 15-minute checks for 48 hours until the IDT (Inter-disciplinary Team) could review, and staff were to get the resident up immediately prior to meal times and activities. The resident would be assisted to the main dining room or activities by staff. The clinical record lacked documentation of an IDT note with RCA (root cause analysis). The therapy screen, dated 2/19/22 indicated the resident had fallen and was on her left side on the floor. Intervention indicated to tilt the resident's wheelchair. The resident was on therapy caseload. The nurse's note, dated 3/17/22 at 6:50 p.m., indicated the resident's roommate called staff to the room. The resident had rolled out of the right side of her bed and hit her head and was bleeding from the center of her forehead. She was sent to the hospital. The nurse's note, dated 3/18/22 at 12:18 a.m.,		plans reviewed and revised as indicated. Any concerns identified will be addressed at that time and additional education will be initiated by the Director of Nursing/Licensed Nursing Designee. On 4/21/22, the Daily CQI Process for reviewing falls was revised by the QAPI Committee to include a Daily Fall CQI Root Cause Analysis Tool. The Intradisciplinary team will be responsible to ensure fall interventions are completed based on the Root Cause Analysis of each event. 4) On 4/21/22, the Daily CQI Process for reviewing falls was revised by the QAPI Committee to include a Daily Fall CQI Root Cause Analysis Tool. The Intradisciplinary team will be responsible to ensure fall interventions are completed based on the Root Cause Analysis of each event The Director of Nursing/Designated Nursing will complete random Fall quality reviews using the Fall Quality Review Audit Tool, to validate that documentation is complete including change of condition, MD/RP notification, pain assessments, 72-hour clinical documentation, neuro checks (if indicated) and completion of the Daily Fall CQI root cause analysis tool. Any concerns identified	

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	indicated the resident would be returning to the facility with no new orders. The clinical record lacked documentation of an IDT note with RCA (root cause analysis). The Therapy screen, dated 3/17/22, indicated the resident rolled out of bed. The intervention specified for the resident to be up at all meals. During an interview, on 4/5/22 at 10:42 a.m., the MDS Coordinator indicated IDT follow-up notes should be located in the nurse's note, as an IDT note. During an interview, on 4/5/22 at 11:02 a.m., the ED (Executive Director) indicated they were unable to find IDT notes. The former DON (Director of Nursing) had not entered them into the system. The MDS Coordinator did the care plan updates while they were doing the IDT review. The RCA would be placed in the IDT note generally. When they discussed it in the clinical meeting, they would review what the resident was doing, when they fell, and see if it was something that had occurred before, what they did prior to, and make sure were not duplicating an intervention or doing something that has already been tried. A temporary intervention should be placed immediately, until the IDT team could review. During an interview, on 4/5/22 at 11:50 a.m., CNA (Certified Nurse Aide) 3 indicated the resident had fallen prior. The resident required the assistance of 2 staff members and had to be supervised so she didn't fall out of her chair. The resident usually got up for at least lunch and dinner. During an interview, on 4/5/22 at 11:57 a.m., the		during the quality reviews will be addressed at the time of the review and additional education will be completed at that time. The Fall Quality Review Audit will be completed on five days a week for twelve weeks. The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. (A minimum of seven months must be completed). Date of completion: 4/26/22	

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	MDS Coordinator indicated dinner began serving around 4:45 p.m., and was usually concluded by 5:40 p.m. During an interview, on 4/5/22 at 12:19 p.m., Resident D's roommate, Resident E, indicated she had to hit her call light for Resident D just a few minutes prior, when the resident had almost fallen out of bed. Staff came in and put her back in the middle of the bed. Her head was off the bed, and she was trying to use her table to pull herself up in the bed. She had fallen out of bed previously a few weeks ago. Resident E indicated she was taking a nap, and Resident D woke her telling her she was falling. She called for help and the resident fell out of bed. It had happened around an hour after dinner. Resident D couldn't reposition herself. During an interview, on 4/5/22 at 12:48 p.m., the ED indicated for the fall on 2/19/22, getting up for meals was just the immediate intervention until the IDT could review. She believed the intervention for that was because they had gotten her up and it was too long of a time she had sat there. They felt if the resident was going to be gotten up for meals or activities it needed to be right before they happened. That was the immediate intervention. Since it happened on the 19th, it would have been reviewed on that following Monday, but if they changed the intervention, it wouldn't have made it into the care plan. For the fall on 3/17/22, she was not sure why getting the resident up for meals would have been an intervention, if she fell at 6:50 p.m. She stated, "That's not even an appropriate thing for her for that time frame." The ADON and DON were supposed to be doing an IDT note. Sometimes they would provide a mat beside the bed, a scoop mattress would be an option. They may need to assess Resident D for an enabler bar			

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	for her left side of her bed to help her with positioning. The most recent, undated, Incidents/Accidents/Falls policy, provided on 4/5/22 at 1:00 p.m., by the ED, included, but was not limited to, "... After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management... The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated, and resolved... Procedure... 9. A completed incident/accident report that has been documented... will be reviewed by the Director of Nursing and the IDT... during the next CQI meeting... 11. All falls will have a site investigation by appropriate staff in an effort to define the 'root cause' of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new intervention rolled out..." This Federal tag relates to Complaint IN00376272. 3.1-45(a)(1)			