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	01/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00396706, IN00398271, IN00398311 and IN00398340. Complaint IN00396706 - Substantiated. Federal/State deficiency related to the allegations is cited at F600. Complaint IN00398271 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00398311 - Substantiated. Federal/State deficiency related to the allegations is cited at F600. Complaint IN00398340 - Substantiated. Federal/State deficiency related to the allegations is cited at F600. Survey dates: January 3 and 5, 2023 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 10 Medicaid: 30 Other: 24 Total: 64 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hewitt	Administrator	02/06/2023

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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	Quality review completed on January 10, 2023.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure resident to resident (Resident B) sexual abuse did not occur and staff to resident (Resident D) verbal abuse did not occur for 2 of 3 residents reviewed for abuse. Findings include: 1.. The clinical record for Resident D was reviewed on 1/3/23 at 10:43 a.m. The diagnoses included, but were not limited, acute pulmonary edema, aphasia, diabetes, encephalopathy, diffuse traumatic brain injury, unstageable pressure ulcer, and bilateral above the knee amputations. The admission MDS (Minimum Data Set), dated 12/16/22, indicated the resident's cognition was severely impaired. The progress note, dated 12/23/22 at 9:00 p.m.,	F 0600	Waters of Scottsburg POC Complaint Survey 1/3/23 Deficiency ID: F _ 0000 Completion Date: January 31, 2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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. Facility's date of alleged	01/31/2023

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	indicated the resident had swelling, redness, and warmth to his left jaw. A new order was received to send the resident to the emergency room for evaluation. EMS (emergency medical services) was called, and report called to the hospital. The resident was transferred to the stretcher and taken to the hospital. The EMS report, dated 12/23/22 at 9:19 p.m., indicated EMS was dispatched, non-emergent to the facility. RN (Registered Nurse) 6 approached EMS upon entrance and stated she had noticed the mass on Resident D's jaw when her shift began. Resident B was a diabetic, double knee amputation since admission, and does not take care of himself. EMS personnel, RN 6 and CNA (Certified Nurse Assistant) 5 moved the resident to the stretcher. EMS personnel began to move Resident D out of his room at which time RN 6 patted the resident on the head and said, "Get help even if you are a dick" and then "good luck, don't come back to me tonight." EMS personnel moved Resident B out of the facility and into the ambulance. During a telephone interview on 1/4/23 at 1:11 p.m., with EMT (emergency medical technician) 15 and EMT 16 indicated on 12/23/22, they were dispatched to the facility and arrived at the resident's room at 9:10 p.m. Prior to entering the Resident B's room, RN 6 informed EMT 15 and EMT 16 the resident was a drug addict and did not take care of himself. Once in the room, Resident B was transferred with a sheet up onto the stretcher by EMT 15, EMT 16, RN 6 and CNA 5. The CNA exited the room. The EMTs secured the resident on the stretcher. Prior to exiting the resident's room, RN 6 walked up to the resident on the stretcher and tapped the resident on the forehead and said, "get help even if you are a		compliance is: January 31, 2023. Facility is respectfully requesting paper compliance for all deficiencies in this POC. F-600 It is the policy of this facility to prevent resident abuse, neglect, mistreatment, and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. Residents who reside in the facility have the potential to be affected by this finding. On 1/4/23 Facility wide interviews were conducted to ensure that no other residents had any complaints or allegations related to abuse. Social Services Director/Designee will monitor by interviewing 10 residents weekly for a period of 4 weeks, then 5 residents weekly for a period of 4 weeks and then 1 resident weekly for a period of 4 months. If facility is 100% compliant at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator on___1/31/23____for all staff the following was reviewed: 1. Abuse 2. Resident Rights / Elder Justice Act 3. Abuse Reporting Guidelines 4. Customer Service	

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	dick". They moved the resident to the exit door at which time RN 6 said "good luck and don't come back to me tonight." During a telephone interview on 1/4/23 at 2:11 p.m., CNA 5 indicated she could not deal with Resident D by herself, and the resident had punched RN 6 in the face twice that evening (12/23/22). She had assisted with the transfer of the resident from the bed to the stretcher. After transferring the resident with RN 6 and the EMTs she asked RN 6 if she needed anything else. The RN replied no and then the CNA left the room. During an interview on 1/5/23 at 12:24 p.m., RN 6 indicated on 12/23/22, the resident was very confused, seemed off and kept trying to get in the hallway. She then noticed the resident had a swollen left jaw, called the physician, and got an order to send the resident out to the hospital for evaluation. When EMS arrived, Resident B was in the doorway. She got him on a sheet and "pulled the resident back over by his bed by herself." 2. a. The clinical record for Resident B was reviewed on 1/3/23 at 1:33 p.m. The diagnosis included, but was not limited to, vascular dementia. The annual MDS assessment, dated 9/27/22, indicated the resident's cognition was moderately impaired. The incident report, dated 12/7/22 at 4:30 p.m., indicated Resident B walked to a table where Resident C was sitting participating in an independent activity. Resident B approached the table in his wheelchair, reached under the table, and touched Resident C's chest. The residents were separated, and Resident B was placed on 1:1 (one staff to one resident) supervision.		Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the Social Services Director /Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	The progress note, dated 12/7/22 at 4:50 p.m., indicated the resident approached a female resident in his wheelchair and touched the female resident's breast. The incident report, dated 12/9/22 at 11:45 a.m., indicated Resident B was sitting at dining room table with a staff member who was providing 1:1 supervision. Resident C walked up to the table and Resident B reached out and made contact with her breast. The residents were separated, and Resident B was moved off of the dementia unit and placed on 1:1 supervision. The progress note, dated 12/9/22 at 16:30, indicated Resident B was sitting at a dining room table when a resident walked up to the table and Resident B reached out his arm and made contact with the female resident's chest. The residents were immediately separated and Resident B was placed on 1:1 supervision. During an interview on 1/3/23 at 2:10 p.m., QMA (Qualified Medication Aide) 3 indicated she worked on 12/7/22. Resident B kept going over to the table where Resident C was sitting and was redirected. Resident B made contact with the side of Resident C's chest and was trying to rub her breast. The residents were separated, and Resident B was placed on 1:1. During an interview on 1/3/23 at 2:17 p.m., CNA 4 indicated on 12/9/22, Resident B was sitting at a table. Resident C came up the table and sat down. Resident B wheeled his wheelchair closer to Resident C, reached out and grabbed her breast. It was reported to her that Resident B was on 15-minute checks. b. The clinical record for Resident C was reviewed			

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	on 1/3/23 at 1:58 p.m. The diagnoses included, but were not limited to, intellectual disabilities, mood disorder and schizoaffective disorder. The incident report, dated 12/7/22 at 4:30 p.m., indicated Resident C was sitting at a table participating in an independent activity. Resident B approached the table in his wheelchair, reached under the table and touched Resident C's chest. The residents were separated, and Resident B was placed on 1:1 supervision. The incident report, dated 12/9/22 at 4:30 p.m., indicated Resident B was sitting at dining room table with a staff member who was providing 1:1. Resident C walked up to the table and Resident B reached out and made contact with her breast. The residents were separated. Resident B was moved off the dementia unit and placed 1:1. The progress note, dated 12/9/22 at 4:45 p.m., indicated Resident C walked up to a male resident sitting at a dining room. The male resident reached his arm out and made contact with this resident's chest. The residents were immediately separated. On 1/3/23 at 10:57 a.m., the Executive Director provided a current, undated copy of the document titled "Abuse Prevention Program". It included, but was not limited to, "Policy...It is the policy of this facility to prevent resident abuse...Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...Abuse Reporting...This facility will not tolerate resident abuse...by anyone, including staff member, other residents...Verbal Abuse...Any use of oral...language that willfully includes disparaging and derogatory terms to residents...Sexual Abuse...Including, but not limited to, sexual			

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	harassment.... This Federal tag relates to Complaints IN00396706, IN00398311 and IN00398340 3.1-27(a)(1) 3.1-27(b)			