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	01/17/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00399254. Complaint IN00399254 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: January 9, 10, 12, 13, and 17, 2023. Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 12 Medicaid: 30 Other: 20 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 19, 2023.	F 0000	**Waters of Scottsburg** **Annual Recertification Survey** **1/17/2023** Deficiency ID: F _ 0000 Completion Date: February 2, 2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action, 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 compliance is: February 2, 2023. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

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	01/17/2023

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
	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	01/17/2023

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
	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician for a blood sugar level over 400 for 1 of 2 residents reviewed for Notification of Change. (Resident 39) Findings include: The clinical record for Resident 39 was reviewed on 1/9/23 at 11:08 a.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy. The Quarterly MDS (Minimum Data Set) assessment, dated 12/20/22, indicated the resident was cognitively intact. The care plan, dated 11/29/22, indicated the resident had diabetes with the risk of hyper/hypoglycemia. The interventions included, but were not limited to, antidiabetic medications per order, check blood sugars per order, labs per order, monitor for signs and symptoms of hyperglycemia such as but not limited to, flushed, fruity breath, thirst, diaphoretic, monitor for signs and symptoms of hypoglycemia such as pale, clammy, cool, thready pulse, lethargy, notify the physician and family as needed. The physician's orders, initiated on 9/12/22, indicated facility staff must notify the physician for blood sugars less than 60 or greater than 400. Place a progress note in the chart regarding notification of the physician and family. The Blood Sugar Summary indicated the resident's blood sugar level was 408 on 1/8/23 at 11:13 p.m.	F 0580	**F-580** It is the policy of the facility to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) including abnormal blood sugar readings in diabetic patients. Residents who reside in the facility have the potential to be affected by this finding. On 1/18/23 a complete audit of the past 30 days was completed for all diabetic residents to ensure proper notification was made for abnormal blood sugar readings. Notification was made to the MD for out of range blood sugar for Resident 39. Director of Nursing/Designee will monitor blood sugars and MD notifications on 10 diabetic residents weekly for 4 weeks, 5 residents weekly for 4 weeks and then 1 resident weekly for 4 months. If facility is 100%	01/31/2023

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	01/17/2023

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
	The clinical record lacked documentation indicating the physician and family was notified and a progress note was placed in the clinical record. The resident's blood sugar was not rechecked until 1/9/21 at 8:46 a.m. During an interview on 1/17/23 at 10:23 a.m., LPN (Licensed Practical Nurse) 9 indicated if a resident's blood sugar was below 60 or above 400 the doctor should be called. She would recheck the resident's blood sugar in 1 hour. During an interview on 1/17/23 at 10:29 a.m., the DON (Director of Nursing) indicated when a blood sugar was below 60 or above 400 the staff should call the doctor for further orders. The blood sugar should be checked again within 30 to 45 minutes. The nurse should document in the clinical record the physician was called and new orders received. The current Blood Glucose Monitoring policy was provided by the Executive Director on 1/17/22 at 10:13 a.m., and included, but was not limited to, ("... Follow the sliding scale parameters for fast acting insulin and any additional orders received from the physician. Note: Immediately notify the physician and the resident's representative any time the resident's blood sugar is outside the ordered parameter range as well as any interventions taken to address a hypoglycemic or hyperglycemic event...Complete all appropriate documentation.") 3.1-5(a)(2)		compliant at the end of 6 months; then monitoring can be stopped. At an in-service held by the Director of Nursing on___1/26/23____for all staff the following was reviewed: 1. Diabetic policy and procedures 2. MD and Family Notifications 3. Proper documentation of notifications. 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 Director of Nursing / 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.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	01/17/2023

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
	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure relief interventions were implemented for 1 of 4 residents reviewed for Pressure Ulcers. (Resident 263) Findings include: The clinical record for Resident 263 was reviewed on 1/11/23 at 10:00 a.m. The diagnoses included, but were not limited to, muscle wasting and atrophy, unsteadiness on feet, difficulty in walking, lack of coordination, weakness, peripheral vascular disease, type 2 diabetes. The Admission Assessment, dated 12/31/22, indicated the resident required limited assistance with bed mobility and transfers and was admitted with a pressure area to the left heel. The weekly wound evaluation, dated 1/1/23, indicated the resident had an unstageable pressure injury to the left heel which measured 3 cm (centimeters) in length by 2.8 cm in width with no measurable depth. The wound color was brown and black. A treatment of betadine to left heel and nonadherent dressing was put into place.	F 0686	**F-686** It is the policy of the facility to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Including to ensure pressure relief interventions are in place for residents with pressure ulcers.	01/31/2023

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	01/17/2023

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
	Preventative interventions included heel boots. The physician's order, dated 1/1/23, indicated to apply an off loading boot to the left heel every shift for wound healing. The weekly wound evaluation, dated 1/1/23, indicated the resident had an unstageable pressure injury to the left heel measuring 3 cm in length by 2.8 cm in width, by 0 cm in depth. The wound color was brown and black. The current treatment was betadine and a non-adherent dressing. The weekly wound assessment, dated 1/5/23, indicated the wound measured 3.72 cm in length by 3.36 cm in width, by 0.1 cm in depth. There was no exudate. The wound was 20% granulation and 80% slough. The order was updated to cleanse the left heel with normal saline, pat dry, apply medihoney to wound bed, and cover with a bordered dressing every 3 days and as needed for soilage. The current preventative interventions included a specific turning and repositioning program and heel boots. The clinical record lacked documentation of any further interventions to relieve pressure from the resident's left heel while out of bed. During an observation on 1/10/23 at 9:04 a.m., the resident was sitting in her chair in her room. She had a dressing to her left heel which was dated 1/9/23. There were no pressure relief boots in place. The resident was resting her heel directly on the floor. She indicated she did not have any boots here at the facility, though she had them at home prior. She received the wound from rubbing her heel on the bed at the last facility she was in.		Residents who reside in the facility have the potential to be affected by this finding. On 1/18/23 a complete audit was done for all residents with wounds that all treatment orders including wound dressings and pressure relieving interventions were in place and being followed as ordered. Order was changed on Resident 263 to reflect heels to be floated while resident in bed. Director of Nursing/Designee will monitor wound treatments and pressure relief interventions for 10 residents weekly for 4 weeks, 5 residents weekly for 4 weeks and then 1 resident weekly for 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 Director of Nursing on___1/26/23____for all staff the following was reviewed: 1. SWAT policy and procedure 2. Following MD Orders 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	

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	01/17/2023

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
	During an observation on 1/12/23 at 9:37 a.m., Resident 263 was resting abed with a dressing in place to her heel which was undated but appeared intact and clean. There was no boot observed in the room. Her heels were resting directly on the bed. The resident indicated she did not have a boot in her room. During an observation on 1/12/23 at 11:18 a.m., Resident 263 was sitting in her wheelchair. She had a sock in place but no boot. Her heel was resting directly on the floor. During an observation on 1/12/23 at 11:35 a.m., The ADON (Assistant Director of Nursing) and Wound Care NP (Nurse Practitioner) provided wound care for the resident. The Wound Care NP indicated the wound was approximately 80% eschar and 20% granulation. The resident had a silver dollar sized wound to the left heel with the majority of the wound being black tissue, and an inner ring of pink to red tissue observed. The edges of the wound were soft and white. The Wound care NP indicated they offloaded the heel. She recommended offloading with a pillow for more ambulatory residents. During an observation on 1/13/23 at 11:24 a.m., the resident was sitting in her chair in her room. She did not have a boot in place. During an observation on 1/13/23 at 11:27 a.m., the DON (Director of Nursing) asked the resident if staff had been putting a boot on her and the resident replied they were not. The DON looked around the room and could not locate a pressure relief boot. During an interview on 1/13/23 a 11:31 a.m., LPN (Licensed Practical Nurse) 6 indicated if a resident		monitoring of the Director of Nursing / 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.	

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	01/17/2023

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
	had pressure relief boots the aides were to put them on and nurses were to make sure they were on there. They called them off loading boots and she had an order for those to the left heel. She had an area on her left heel. She was to wear them every shift when she was in bed or up, if she didn't have her shoes on. They should be applied by nursing staff. During an interview on 1/13/23 at 11:34 a.m., the ADON indicated the order should say to offload the resident heels and should have been clarified. The resident's heels, the left heel specifically should have been up off the bed. During an interview on 1/13/23 at 11:35 a.m., CNA (Certified Nursing Aide) 7 indicated she usually put the resident's feet up with a pillow under them so her heels were not touching anything. She did not have a boot and she sat in her chair a lot. They needed to find some legs for her wheelchair so they could raise her feet up and put a pillow under her legs. She did not have any interventions specific to when she was up in her chair. The most current, undated Preventative Skin Care policy, provided on 1/13/23 at 2:55 p.m. by the Executive Director, included, but was not limited to, "... Procedure... 6) Positioning pillows or specialty devices may be used between two skin surfaces or to slightly elevate bony prominences/pressure areas off the mattress. 7) Heels Up or specialty ordered therapeutic boots may be used to protect heels on those residents identified to be high risk. 9) Pillows may be used to float heels to prevent potential pressure sores on those residents identified to be high risk..." 3.1-40(a)(1)			

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	01/17/2023

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 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure interventions to prevent recurrent urinary tract infections (UTIs) were developed for	F 0690	**F-690** It is the policy to ensure that a resident who is continent of	01/31/2023

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	01/17/2023

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
	1 of 3 residents reviewed for bowel and bladder. (Resident 19) Findings include: The clinical record for Resident 19 was reviewed on 1/10/23 at 12:56 p.m. The diagnoses included, but were not limited to, chronic kidney disease and urinary tract infection. The nurse's note, dated 10/10/22 at 6:30 a.m., indicated the resident had much confusion. She was sent to the hospital for evaluation and treatment. The nurse's note, dated 10/10/22 at 11:36 a.m., indicated the resident returned to the facility from the hospital with a diagnoses of a urinary tract infection and orders for cephalexin 500 mg (milligrams) three times daily for five days. The nurse's note, dated 10/10/22 at 1:46 p.m., indicated the resident's antibiotic was changed to cipro 250 mg twice daily for five days. The nurse's note, dated 10/17/22 at 4:04 p.m., indicated the physician gave an order to repeat the resident's urinalysis with culture and sensitivity. The physician's note, dated 11/1/22 at 11:11 a.m., indicated the resident had increased confusion. New intervention and orders indicated to increase oral fluids. The clinical record lacked documentation of the implementation of any care plan or orders for additional fluids. The nurse's note, dated 11/23/22 at 1:40 p.m.,		bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Including to ensure proper care plan interventions are developed to prevent recurrent urinary tract infections (UTIs) for residents. Residents who reside in the facility have the potential to be affected by this finding. On 1/18/23 a complete audit was completed for all residents with history of recurrent UTI's have additional care plan interventions in place for prevention. Director of Nursing/Designee will monitor the care plans of residents with a history of recurrent UTI's to ensure proper interventions are care planned and in place. The monitoring will include 10 residents weekly for 4 weeks, 5 residents weekly for 4 weeks and then 1 resident weekly for 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 Director of Nursing on___1/26/23____for all staff the following was reviewed: 1. Following physician orders 2. Updating care plan	

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	01/17/2023

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
	indicated the resident had increased anxiety and confusion and her urine was cloudy and foul smelling. The physician new orders were to obtain a urinalysis with culture and sensitivity, if indicated via straight cath. The physician's note, dated 11/23/22 at 1:42 p.m., indicated new orders were given for a urinalysis and new intervention orders indicated to increase oral fluids. The clinical record lacked documentation of any new care plan interventions to increase oral fluids. The nurse's note, dated 11/27/22 at 8:10 a.m., indicated the physician was notified of the preliminary urine culture with results indicating greater than 100,000 E-Coli. New orders were given for Keflex 500 mg three times daily for 10 days. The nurse's note, dated 11/28/22 at 9:06 a.m., indicated the physician's new orders were for the resident to have an urinalysis with culture on day 7 of antibiotic treatment, and a CT (computed tomography) scan of the abdomen and pelvis related to recurrent polynephritis. The nurse's note, dated 12/7/22 at 12:15 p.m., indicated the resident's culture showed less than 10,000 colony forming units of bacteria per milliliter of urine. The colony count was not generally considered to be clinically significant. During an interview on 1/13/23 at 12:55 p.m., LPN (Licensed Practical Nurse) 8 indicated the resident had been out to the hospital before with a urinary tract infection and she had one other urinary tract infection since she had been at the facility. She had a history of UTI's. Staff should make sure she		interventions 3. Additional interventions to prevent recurrent UTI's 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 Director of Nursing / 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.	

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	01/17/2023

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
	was getting good perineal care, encourage toilet use and increase her fluids. She would care plan residents for recurrent UTI's if they had a history of them and include the interventions on their care plan. The resident should have a care plan for recurrent urinary tract infections. They should try and develop a plan of care to monitor and prevent them. She reviewed the resident's care plan at this same time and indicated she could not find one. 3.1-41(a)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on record review, observation, and interview, the facility failed to ensure the kitchen, dry storage room, and equipment were clean and	F 0812	**F-812** It is the policy of Store, prepare, distribute and serve food in	01/31/2023

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	01/17/2023

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
	in good repair for 3 of 3 kitchen observations and safe food handling was maintained for 2 of 2 meal service observations. Findings included: 1. During the initial tour on 1/9/23 between 9:20 a.m. and 9:50 a.m., while accompanied by Cook 10, the following was observed: - The entire stainless steel wall behind and around the dishwasher which extended over to the 3 compartment sink was heavily soiled with whitish streaks and food particles. - The 3 compartment sink was heavily soiled inside and the outside front with a build-up of white substance that was able to be scraped. - The hot water knob to the left sink of the 3 compartment sink was dripping into the sink. - The outside of the dishwasher top had a heavy amount of brown crumbs on it. - The front, sides and 2 equipment boxes connected to the dishwasher had a heavy build-up of soiled material and yellow streaks. - Under the soap dispenser by the dishwasher was an area which measured 4 foot long by 1 foot high of black greasy mold which was able to be scraped. - The soap dispenser by the right side of the 3 compartment sink was dripping blue down from the dispenser, the wall and into the sink. - The wall on the back of the stove and flat top had a heavy build-up of black/brownish grease that was able to be scraped. - The 2 stove doors had blackish/brown streaks down the entire doors that culminated into spots at the bottom of the doors. - There was a heavy build-up of black substance around all the burners on the stove which was flaking		accordance with professional standards for food service safety. Including to ensure to ensure the kitchen, dry storage room, and equipment are clean and in good repair and safe food handling is maintained throughout meal service. Residents who reside in the facility have the potential to be affected by this finding. On 1/18/23 a complete deep cleaning of the kitchen occurred. The kitchen cleaning logs were audited to ensure cleaning was routine cleaning was taking place. The chipped ceiling finish and paint was repaired. Dietary Manager/Designee will monitor the kitchen cleaning logs 5 days weekly for 4 weeks, 3 days weekly for 4 weeks and then 1 day weekly for 4 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. Administrator/Designee will monitor the meal service 5 days weekly for 4 weeks, 3 days weekly for 4 weeks and then 1 day weekly for 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	

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	01/17/2023

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
	- In the dry storage had one foot surrounding the smoke detector in the ceiling was an area of chipping and cracked paint which was directly above the entrance into the walk-in fridge During the lunch meal observation between 11:15 a.m. to 12:30 p.m., the following was observed: - All areas identified at 9:20 a.m. remained the same. - The food processor base was observed to be soiled with tan and orange spots - the cook was then observed to begin to puree the meatloaf; he then proceeded to wash the food processor and replaced it on the soiled base and walk away to another task. - The ceiling above the tray line prep area next to the fluorescent light fixture had an area of cracked ceiling plaster which measured 1 foot by 1 foot. - The hot plate lids rack bottom shelf had a moderate amount of food particles. During a kitchen observation on 1/10/23 at 10:10 a.m., the following was observed: - The same areas identified on 1/9/23 at 9:20 a.m. and 11:15 a.m. remained the same with the exception of the hot plate lid rack which was now clean. During an interview with the Dietary Manager at this time, he indicated maintenance was supposed to come and paint everything in the kitchen, but there was no set time frame. He did not know how long the chipping ceiling had been like that. Review of the November 2022, December 2022, and January 2023 as-completed cleaning schedules presented by the Dietary Manager on		Administrator on___1/26/23____for dietary staff and maintenance the following was reviewed: 1. Kitchen cleaning policy and procedure 2. Environmental repairs policy and procedures – related to chipping paint on walls and ceilings. 3. Proper documentation of kitchen cleaning logs. At an in-service held by the Administrator on___1/26/23____for all staff the following was reviewed: 1. Hand hygiene policy and procedures 2. Policy and procedures related to meal service / handling resident food 3. Proper documentation of kitchen cleaning logs. Any staff who fail to comply with the points of the in-services will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the Dietary Manager/ Administrator / Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If	

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	01/17/2023

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
	1/13/23 at 11:00 a.m. indicated the following: - Both ovens, the range top and stainless steel back splash and shelf, 3 compartment sink clean and sanitized, food processor were cleaned daily by the A.M. and the P.M. cooks. - The dishwasher was cleaned daily inside and out by the P.M. dietary aide. The aide also deep cleaned the dish room and de-limed the dish machine on a weekly basis. - The P.M. cook deep cleaned the range weekly making sure to remove and clean the range top burners. 2. During a lunch observation in the dementia unit on 1/9/23 at 12:00 p.m., the Social Service Director dropped the lid, covering the plate, into the mashed potatoes and gravy. She pulled the lid from the food and served it to Resident 20. She then pressed her knuckle against his cornbread, to apply butter. She had not used hand sanitizer or hand washing during the entire meal service. During a lunch observation in the dementia unit on 1/12/23 at 11:47 a.m., the meal cart arrived, and the following was observed: -The Social Service Director pulled Resident 17's wheelchair up to the table and then obtained and delivered Resident 24's food. No hand sanitizer or hand washing was used. The Social Service Director's thumb was against the toast of Resident 24's plate. -No hand sanitizer was used by her when she obtained Resident 17's food or when she opened his milk carton. -She then obtained Resident 11's tray. She did not use hand sanitizer. -Resident 53 was eating Resident 6's food, while Resident 6 was in the restroom. The Social Service Director was notified, and she covered Resident		necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	01/17/2023

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
	6's, plate and pushed it aside on the table. -She rubbed Resident 8's back and obtained a tray for Resident 10 and delivered the tray to her in her room. -She returned to the drink cart and without using hand sanitizer, obtained a drink for Resident 8. -The Activities Director brought Resident 6 back to the table. She placed the covered plate in front of the resident and removed the lid. She was notified of Resident 53 eating a portion of Resident 6's food. The Activities Director took the plate to the dining room and returned with a fresh plate of food for Resident 6. -The Social Service Director adjusted Resident 17's glasses and cut up his spaghetti and fed him. She opened his grilled cheese sandwich foil and touched the bread, before stopping to use a fork, to pull out the grilled cheese sandwich. She then patted Resident 15 on the back and left the dining room. She had not used hand sanitizer during the entire meal service. During an interview on 1/17/23 at 10:56 a.m., the Social Service Director indicated she would use alcohol gel between each tray service, then she would wash her hands. When Resident 53 ate out of the tray, she should have replaced the tray. If a resident was redirected, adjusted or touched, she should have wash her hands. Staff used silverware to hold bread products to apply butter or condiments. During an interview on 1/17/23 at 11:02 a.m., the DON (Director of Nursing) indicated she wasn't sure if there was a policy for how to serve residents. She did not know what the facility policy for hand gel was. The current Glove and Hand Washing Procedures policy was provided by the Regional Nurse on			

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	01/17/2023

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
	1/17/23 at 11:34 a.m. The policy included, but was not limited to, "... 4. Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident... 5. Gloves are to be used whenever direct food contact is required with the following exception: bare hand contact is allowed with foods that not in a ready to eat form, and that will be cooked or baked..." 3.1-21(i)(3) 3.1-21(i)(2)			