STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155494	B. WING	11/09/2021	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R		TODD DR	
\\\\\TEDG	OF SCOTTSBUR	C THE		SBURG, IN 47170	
		·			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
		nvestigation of Complaints	F 0000		
		366019, and a COVID-19			
	Focused Infection (Control Survey.			
	_	5903 - Substantiated.			
	Federal/State defici				
	allegations is cited	at F68/.			
	C 1 ' (DI0026)	(010 0.1 4 4 1			
		6019 - Substantiated.			
		encies related to the			
	allegations are cited	l at F563, F580, and F656.			
	Survey dates: Nove	ember 5, 8, and 9 2021			
	Facility number: 00	00478			
	Provider number: 1				
	AIM number: 1002				
	7 Mivi number. 1002	270430			
	Census Bed Type:				
	SNF/NF: 69				
	Total: 69				
	Census Payor Type	:			
	Medicare: 5				
	Medicaid: 47				
	Other: 17				
	Total: 69				
	These deficiencies	reflect State Findings cited in			
	accordance with 41	0 IAC 16.2-3.1.			
		pleted on November 16,			
	2021.				
- 0566	400 40/5/10/10/10				
F 0563	483.10(f)(4)(ii)-(v)				
SS=D	Right to Receive/[
Bldg. 00	9483.10(1)(4) The	resident has a right to			
	1			I .	i

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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Facility ID:

000478

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 155494	A. BUILDING B. WING	<u> </u>		
NAME OF PROVIDER OR SUPP	IER		ADDRESS, CITY, STATE, ZIP CODE I TODD DR		
WATERS OF SCOTTSB	IRG, THE		ISBURG, IN 47170		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
time of his or hresident's right applicable, and impose on the (ii) The facility access to a resother relatives resident's right at any time; (iii) The facility access to a resvisiting with the subject to reast restrictions and withdraw cons (iv) The facility access to a resindividual that or other service the resident's access to a resident's access to access to a resident's access to access to access to access to access to access	must provide reasonable ident by any entity or provides health, social, legal, as to the resident, subject to ght to deny or withdraw time; and must have written policies and arding the visitation rights of ding those setting forth any sary or reasonable restriction asafety restriction or limitation, rations may apply consistent ments of this subpart, that the end to place on such rights and the clinical or safety nitation. The wand record review, the ensure a resident's (Resident B) and compassionate care visits for reviewed for resident rights.	F 0563	Preparation and execution of the plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The proof correction is prepared and	he	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155494	B. WING			11/09/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
\A/A TED	05 000TT0BUD	S. T. I.E.			TODD DR		
WATERS OF SCOTTSBURG, THE			SCOTT	SBURG, IN 47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 11/5/21 at 1:08 p	o.m. Diagnoses included, but			executed solely because feder	al	
	were not limited to,	dementia, repeated falls,			and state law require it.		
		ive communication deficit.			Compliance has been and will	be	
					achieved no later than, the las	t I	
	Review of the reside	ent's admission record face			completion date identified in th	e	
	sheet indicated he w	vas married.			POC. Compliance will be		
					maintained as provided in the	plan	
	The clinical record	lacked documentation that			of correction. Failure to dispute		
	compassionate care	visits was offered to			challenge the alleged deficient		
	Resident B's spouse				below is not an admission that	-	
	•				alleged facts occurred as		
	During an interview	on 11/9/21 at 9:54 a.m., the			presented in the statements. T	his	
	Social Services Dire	ector indicated the resident's			report in its entirety has been		
	spouse was not offe	red compassionate care			reviewed by our quality		
	visits.	•			Assurance Committee.		
	The Long-Term Car	re Newsletter 2020-72, dated					
	_	ed, but was not limited to, "As			F563 Right to receive/Deny		
		ential Family Caregiver			Visitors		
		ned by the state in June 2020.					
	-	s a family member or other			1. 1. Resident B no		
		who provided regular care and			longer resides in the facility.		
		ent before the pandemicto					
		and support to the resident			2. 2. Residents		
	during the public he	ealth emergency. This care and			residing in the facility were		
		ir in the resident's room only			identified by the		
		as of the long-term care			Executive Director on		
		O 20-39 allows visitation			11/10/2021, as having the		
		isitation is otherwise			potential to be affected by the		
	restricted"				facility process for allowing		
					residents access to visitors.		
	This Federal tag rela	ates to Complaint					
	IN00366019.				3. On 11/10/2021, Director	of	
					Nursing and Executive Directo	r]	
	3.1-8(a)				reviewed the procedure for		
					"visitation and compassionate		
					care visits" and revised the		
					process to include CMS		
					Guidelines for visitation. Socia	al	
					Services sent emails to family		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155494	A. BUILDING B. WING	<u>00</u>	COMPLETED 11/09/2021		
		100494	_		11/03/2021		
NAME OF P	ROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR				
WATERS	OF SCOTTSBUR	G, THE		TSBURG, IN 47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
				members regarding the revise	d		
				visitation process.			
				On 11/10/2021, the Executive			
				Director-initiated education wi			
				administrative staff regarding			
				revised visitation guidelines. (The		
				administrative staff included th	пе		
				following participants: Director			
				Nursing, Assistant Director of			
				Nursing, Social Services, Diet	ary		
				Manager, Social Services,			
				Business office Manager, MD			
				Coordinator, Therapy Director			
				Activity Director, Maintenance			
				and Dietary Manager).			
				4. On 11/26/21, a Visitatio	n		
				Quality Review Audit was			
				reviewed and accepted by the	,		
				Quality Assurance Performan	ce		
				Improvement Committee. The			
				Executive Director /Designate			
				Administrative Staff will compl			
				random Visitor reviews using to Visitation Quality Review Tool			
				validate that residents are	, 10		
				provided visitation that allows			
				immediate access to the resid	ent		
				by immediate family and other	r		
				relatives of the resident, subje	ect to		
				the resident's right to deny or			
				withdraw consent at any time;			
				immediate access to the resid by others who are visiting with			
				consent of the resident, subject			
				reasonable clinical and safety			
				restrictions and the resident's			
				right to deny or withdraw cons	ent		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
III,DI LIIII	o. condenion	155494	B. WING	00	11/09/2021	
		· .	CLDEEL	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
NAME OF P	ROVIDER OR SUPPLIER			I TODD DR		
WATERS	OF SCOTTSBURG	G, THE		TSBURG, IN 47170		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION	
TAG	KEGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			
				at any time; reasonable acce a resident by any entity or	22 IO	
				individual that provides health	ո.	
				social, legal or other services		
				the resident, subject to the		
				resident's right to deny or		
				withdraw consent at any time		
				The Visitation Quality Review	/ will	
				be completed on five residen		
				week for twelve weeks to ens		
				appropriate visitation allowar		
				Any concerns identified durin	9	
				the visitation reviews will be		
				addressed at the time of the review and additional educat	ion	
				will be completed at that time		
				Following the initial twelve-we		
				audit, the Visitation Quality R		
				Audit will be completed on te		
				residents a month for four mo	onths.	
				The results of these audits w	ill be	
				submitted to the Quality		
				Assurance Performance	- 4 la la c	
				Improvement Committee modern The QAPI Committee will	iuliy.	
				determine if additional educa	tion	
				or competencies are required		
				based on the compliance rep	, I	
				from the Quality Reviews. Au		
				will continue monthly until 10		
				compliance has been determ		
				by the QAPI committee. (For		
				future reference the QAPI		
				committee consists of the		
				Medical Director, Director of		
				Nursing and at least two of the	ne	
				following team members:		
				Executive Director, Assistant		
			1	Director of Nursing, Social		

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494		IDENTIFICATION NUMBER:	ľ	JILDING	onstruction 00	(X3) DATE COMPL 11/09/	ETED
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WATERS	S OF SCOTTSBURG	S, THE	1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAU	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAU	Services, Dietary Manager, Social Services, Business offi Manager, MDS Coordinator, Therapy Director, Activity Director, Maintenance, Dietary Manage, licensed and certified staff).	y	DATE
					- Date of Completion-12/2/2021		
F 0580 SS=D Bldg. 00	etc.) §483.10(g)(14) No (i) A facility must in resident; consult we physician; and not her authority, their when there is- (A) An accident interesults in injury and requiring physician (B) A significant of physical, mental, or is, a deterioration psychosocial status conditions or clinic (C) A need to altered (that is, a need to form of treatment or consequences, or of treatment); or (D) A decision to the side of the side o	diffication of Changes. Intermediately inform the with the resident's ify, consistent with his or resident representative(s) Involving the resident which do has the potential for intervention; mange in the resident's for psychosocial status (that in health, mental, or is in either life-threatening is in either life-threatening is in the resident's in either life-threatening is in either life-t					

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PRINTED: 12/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155494		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	facility must ensur information specificavailable and provide physician. (iii) The facility must resident and the ready, when there is (A) A change in reassignment as specified in paragraphs of the facility must update the addressignment and the representative (s). §483.10(g)(15) Admission to a confacility that is a configuration, include that comprise the and must specify that is a confacility failed to ensure the hospital for 1 of family notification. Findings include: The clinical record	ed in §483.15(c)(2) is rided upon request to the st also promptly notify the esident representative, if som or roommate ecified in §483.10(e)(6); or sident rights under aw or regulations as raph (e)(10) of this st record and periodically is (mailing and email) and the resident mposite distinct part. A mposite distinct part (as must disclose in its lent its physical auding the various locations composite distinct part, the policies that apply to ween its different locations	F 0580	1. 1.Resident B no longer resides at the facility. 2. 2. On 11/10/21, Director of Nursing identified residents who have fallen with the last thirty days and comple a clinical chart review for each resident identified to validate the following items were complete.	in eted hat	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETED			ETED	
		155494	B. W				2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
\A/A TED	OF COOTTOBUD	O THE			TODD DR		
WATERS OF SCOTTSBURG, THE			SCOTT	SBURG, IN 47170			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
	were not limited to,	orthostatic hypertension,			and documented in the clinical		
	dementia, and repea	ated falls.			record; change of condition, M	D	
	•				notification, Responsible		
	The nurse's note, da	ated 10/18/21 at 2:22 a.m.,			Party/Family notification of the		
		nt was found sitting on the			event, and implementation of a		
		cs, with a small laceration on			comprehensive fall care plan.		
		The physician was notified			· '		
		send the resident to the			On 11/10/21, the Director of		
	emergency room for				Nursing identified residents that	at	
					were admitted to the facility wi		
	The nurse's note, da	ated 10/18/21 at 4:29 a.m.,			the last thirty days and comple		
	indicated the resider				a clinical chart review for each		
	emergency room with 4 sutures above right				resident to validate that		
	eyebrow.				comprehensive fall care plans		
	-				were implemented for resident	s	
	The clinical record	indicated the family was not			identified as at risk for falls bas		
		intil 10/18/21 at 11:30 a.m.			on the fall risk evaluation.		
	During an interview	on 11/8/21 at 4:45 p.m.,					
	_	icated when a resident was			3. On 11/26/21, the Directo	r of	
		the family should be notified			Nursing /licensed nurse		
	at the time of transf		designee-initiated education with				
			licensed nursing staff regarding				
	On 11/5/21 at 4:18	p.m., the Director of Nursing		residents' changes of condition			
		copy of the document titled			including notification of the		
	_	it's Condition or Status" and			resident, immediate		
	-	l, but was not limited to, "It is			notification/consult with MD,		
		cility to ensure that the			notification, consistent with his	her l	
		ntative are notified of			authority, the resident		
	•	ent's conditionthe nurse			representative when there is a	$_{n}$ $ $	
	will notify the resid				accident.		
	-	is involved in any accident or					
		in an injuryIt is necessary					
		ent to the hospital"			On 11/26/21 the Executive		
		1			Director and Director of Nursin	ıq İ	
	This Federal tag rela	ates to Complaint			reviewed the policy for "Chang	•	
	IN00366019	1			Resident Condition or Status"		
					found the policy to be acceptal		
	3.1-5(a)(1)(4)				Licensed nursing staff are	= -	
	()(*)(*)				responsible for completing		
			1			l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> COMPLETED			ETED		
		155494	B. WING			11/09/2021	
			STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIEF	₹					
\ \A\A_TEBC	05 000TT00UD	O TUE			TODD DR		
WATERS OF SCOTTSBURG, THE			SCOTT	SBURG, IN 47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· C	DATE
					appropriate notifications. The		
					protocol for reviewing accident	is	
					was revised to include a daily		
					review Monday through Friday	. bv	
					the intradisciplinary team, duri	-	
					the Morning Clinical Meeting to	-	
					ensure appropriate notification		
					have been completed and		
					documented in the resident's		
					clinical record.		
					4. On 11/26/21, a Change	of	
					Condition Quality Review Au		
					was reviewed and accepted by		
					the Quality Assurance	'	
					Performance Improvement		
					Committee. The Executive		
					Director /Designated		
					Administrative Staff will complete	ato	
					random Change of Condition		
					reviews using the Change of		
					Condition Quality Review Tool	to	
					validate notification of the	, 10	
					resident, immediate		
					notification/consult with MD,	/hor	
					notification, consistent with his	/riei	
					authority, the resident	_	
					representative when there is a		
					accident involving the resident		
					which results in injury and has		
					potential for requiring physicial		
					intervention; a significant chan	-	
					in the resident's physical, men		
					or psychosocial status (that is		
					deterioration in health, mental,		
					psychosocial status in either lit		
					threatening conditions or clinic		
					complications); a need to alter		
					treatment significantly (that is		
					need to discontinue an existin	g	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
		155494	b. wind		11/09/2021
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				TODD DR	
WATERS	OF SCOTTSBUR	G, THE	SCOT	ΓSBURG, IN 47170	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				form of treatment due to adve	
				consequences, or to commer	ice a
				new form of treatment); or a	
				decision to transfer or discha	rge
				the resident from the facility.	
				The Change of Condition Qua	ality
				Review will be completed on	-
				residents a week for twelve w	
				Any concerns identified durin	g
				the reviews will be addressed	at
				the time of the review and	
				additional education will be	
				completed at that time. Follow	-
				the initial twelve-week audit,	he
				Change of Condition Quality	
				Review Audit will be complete	
				ten residents a month for four months. The results of these	
				audits will be submitted to the	<u>, </u>
				Quality Assurance Performar	
				Improvement Committee mor	
				The QAPI Committee will	, I
				determine if additional educa	tion
				or competencies are required	,
				based on the compliance rep	orted
				from the Quality Reviews. Au	
				will continue monthly until 10	
				compliance has been determ	
				by the QAPI committee. (For	
				future reference the QAPI	
				committee consists of the	
				Medical Director, Director of	
				Nursing and at least two of the	e
				following team members:	
				Executive Director, Assistant	
				Director of Nursing, Social	
				Services, Dietary Manager,	ioo
1			1	Social Services, Business off	ice

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA				INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING	00	COMPL	
		155494	Б. W.			11/09/	2021
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBURG	i, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Manager, MDS Coordinator, Therapy Director, Activity Director, Maintenance, Dietary Manage, licensed and certified staff).		
F 0656	483.21(b)(1)				- Date of Completion-12/2/2021		
SS=D Bldg. 00	Plan §483.21(b) Compr §483.21(b)(1) The implement a comp care plan for each the resident rights and §483.10(c)(3) objectives and tim resident's medical psychosocial need comprehensive as comprehensive car following - (i) The services the attain or maintain practicable physical psychosocial well-§483.24, §483.25 (ii) Any services the required under §44 but are not provide	n, nursing, and mental and distributions that are identified in the essessment. The control of the resident's highest all, mental, and being as required under or §483.40; and the total of the resident's be 83.24, §483.25 or §483.40 and the total of the resident's control of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155494	B. WING 11/09/2021			/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	3			TODD DR		
WATERS	S OF SCOTTSBUR	G THE			SBURG, IN 47170		
WAILING		G, TTIE		30011			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE	
	. ,	ed services or specialized					
		ices the nursing facility will					
	provide as a resul						
		s. If a facility disagrees with					
	I -	PASARR, it must indicate					
		resident's medical record.					
	` '	with the resident and the					
	resident's represe	• •					
	1 ' '	goals for admission and					
	desired outcomes						
	1 ' '	preference and potential					
	for future discharç						
		r the resident's desire to					
		munity was assessed and					
	1 -	cal contact agencies					
	1	opriate entities, for this					
	purpose.	us in the second benefits					
	1 ' '	ns in the comprehensive					
		ropriate, in accordance					
	(c) of this section.	ents set forth in paragraph					
	` '		E	(5)	l 1. 1. On 11/16/21, th	•	12/02/2021
		and record review, the sure a fall comprehensive	F 00	000	Director of Nursing Services	E	12/02/2021
		ted timely for 2 of 3 residents			reviewed Resident C and Resi	idont	
	reviewed for falls.	ted timely for 2 of 3 fesidents			D's comprehensive fall care pl		
	reviewed for fails.				and determined that the care	alis	
	Findings include:				plans were appropriate.		
	i mamga menade.				Piano wore appropriate.		
	1 The clinical reco	rd for Resident C was			2. 2. On 11/10/21, The		
		1 at 2:13 p.m. Diagnoses			Director of Nursing identified		
		not limited to, dementia and			residents who have fallen with	in	
		The resident was admitted on			the last thirty days and comple		
	9/13/21.				a clinical chart review for each		
					resident identified to validate t		
	The fall risk review	y, dated 9/13/21, indicated the			following items were complete		
	resident was at a hi				and documented in the clinical		
					record; change of condition, M	ID	
	The baseline care n	lan, dated 9/13/21, indicated			notification, Responsible		
		istory of falls and that falls			Party/Family notification of the	;	
	had occurred prior	-			event, and implementation of a		
	l		ı		l ' '		I

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPL	ETED
		155494	B. W	B. WING		11/09/2021	
		100.00		_		, ,	
NAME OF I	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	OF SCOTTSBUR	G, THE		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	T	ID	<u> </u>		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
IAG	REGULATORT OR	LESC IDENTIFY TING INFORMATION)	+	IAG			DATE
	7F1 1'' 1 1	. 1. 4 14 611			comprehensive fall care plan.		
	The clinical record				0 44/40/04 B: 1 6		
	-	e plan was not initiated until			On 11/10/21, the Director of	_	
	10/14/21.				Nursing identified residents that		
					were admitted to the facility wi		
	_	v on 11/8/21 at 4:58 p.m., the			the last thirty days and comple		
	-	g indicated comprehensive			a clinical chart review for each		
	-	e put in place within 21 days			resident to validate that		
	of admission.				comprehensive fall care plans		
					were implemented for resident		
	2. The clinical reco	rd for Resident D was			identified as at risk for falls bas	sed	
	reviewed on 11/5/2	1 at 4:08 p.m. Diagnoses			on the fall risk evaluation.		
	included, but was not limited to, unsteadiness on						
	feet, dementia, Park	cinson's disease, and history			On 11/11/2021, the Director of	:	
	of falls. The resider	nt was admitted on 10/7/21.			Nursing and MDS Coordinator		
					reviewed comprehensive care		
	The fall risk review	y, dated 10/7/21, indicated the			plans for residents residing wit		
		ry of falls within the last 3			the facility to determine if		
	months.				comprehensive care plans have	⁄e	
					been initiated within 21 days.		
	The baseline care p	lan, dated 10/7/21, indicated			resident identified as not havir	-	
	-	istory of falls and that falls			comprehensive assessment	·9 ~	
	had occurred prior	-			completed was identified and	a	
	naa oocarrea prior	a damission.			comprehensive care plan was	•	
	The clinical record	indicated the fall			developed during the review.		
		e plan was not initiated until			developed daring the review.		
	11/1/21.	plan was not initiated until					
	11/1/21.				3. On 11/24/21, Director of	.f	
	On 11/0/21 at 11:29	8 a.m., the Executive Director			Nursing reviewed the procedu		
		copy of the document titled			for "revising of care plans" and		
	•	n Assessment/Comprehensive	· · · · · · · · · · · · · · · · · · ·				
		-	completion of comprehensive care				
		dated. It included, but was not	plans. The process was revised to				
		.The Comprehensive Care			include increased monitoring of	are	
		pand on the resident's risks,			plans to validate that		
	-	ionsProcedureThe			comprehensive care plans are		
	_	re Plan will be finalized within			updated as indicated with new		
		on of the Full Comprehensive			orders and fall interventions. C	are	
	MDS (Minimum D	ata Set) assessments			plans will be updated by the		
					Director of Nursing Services,		
	This Federal tag rel	ates to Complaint			MDS Coordinator or licensed		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 00	(X3) DATE COMPI		
		155494	B. WING		11/09	/2021
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG, THE			1350 N	ADDRESS, CITY, STATE, ZIP COD I TODD DR ISBURG, IN 47170	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	IN00366019 3.1-35(e)(1)			nursing designee. Physic orders will be reviewed designer. Monday through Friday, be intradisciplinary team, due Morning Clinical Meeting assure appropriate care personal in place for new orders prevention interventions. On 11/26/21, the Director Nursing /licensed nurse designee-initiated educat licensed nursing staff regrevision and implementat resident care plans and for physician orders. (This exincluded fall prevention interventions and develop the comprehensive care within 21 days of admissional device with a care perfor limprovement Committee. Director of Nursing /Designational device with a care plans are being developed and implement quality Review Tool, to with the care plans are being developed and implement indicated to meet resident including fall prevention interventions. This audit winclude monitoring to valid	ian aily by the ring the to blanning and fall of ion with arding ion of blowing ducation oment of blan on). re Plan tation as y the mance The gnated aff will lan lan altion altion altidate ted as t needs will also	

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155494	B. WING		11/09/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				comprehensive care plans are completed within the 21-day ti frame allotted by the RAI guidelines.			
				The Care Plan Development/Implementation Quality Review will be comple on five residents a week for tw weeks. Any concerns identified during the reviews will be addressed at the time of the review and additional education will be completed at that time. Following the initial twelve-wee audit, the Care Plan Development/Implementation Quality Review Audit will be completed on ten residents a month for four months. The re of these audits will be submitted the Quality Assurance Performance Improvement Committee monthly. The QAP Committee will determine if additional education or competencies are required, be on the compliance reported fro the Quality Reviews. Audits w continue monthly until 100% compliance has been determin by the QAPI committee. Date of Compliance-12/2/2022	velve d on ek sults ed to I ased om iill ned		
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foo	ot care.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155494	B. W	B. WING		11/09/2021	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
\\/\TED	OF COATTORUE	C THE			TODD DR SBURG, IN 47170		
WATERS	S OF SCOTTSBUR	G, THE		30011	360RG, IN 47 170		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	To ensure that res	sidents receive proper					
	treatment and car	e to maintain mobility and					
	good foot health,	the facility must:					
	I -	re and treatment, in					
	, ,	professional standards of					
		uding to prevent					
	_ ·	n the resident's medical					
	condition(s) and						
	, ,	ssist the resident in					
	1 ' '	ents with a qualified person,					
	•	·					
	and arranging for transportation to and from such appointments.						
	Based on observation, interview and record		F 0	597	1. 1. Resident F wa	96	12/02/2021
	review, the facility failed to ensure resident's		1 1 00	367	foot/nail care by licensed nursi		12/02/2021
		received podiatry care for 2			staff on 11/5/21. Resident H w	•	
	of 5 residents review				provided foot/nail care by licer		
	of 3 residents revie	wed for foot care.			nursing staff on 11/8/21. Follow		
	Eindings in aluda.				_		
	Findings include:				up podiatry has been schedule by social services.	eu	
	1 The clinical reco	rd for Resident F was			by social services.		
		at 3:07 p.m. Diagnosis			2. 2. Residents		
		ot limited to, diabetes.			residing in the facility were		
	included, but was n	of fiffilled to, diabetes.			identified by the Director of		
	0: 11/5/21 -+ 2:45	41 f-11			•	tha	
	On 11/5/21 at 2:45	-			Nursing on 11/8/21 as having	une	
		dent F's toenails were made			potential to be affected by the	ام	
		ed Medication Aide) 14:			facility process for foot care ar	iu	
	-Right foot	and the second s			podiatry services. Licensed		
		as extremely thick, yellow and			nursing staff completed		
	rigged.				observations of resident and		
		toe was long, thick, yellow			provided foot care if needed		
	and curved towards	_		during the review. A list of			
		and 4th toes were yellow,			residents with podiatry needs		
		nderneath the top of the toes.			submitted to the social worker		
		toe was long and curved			The social worker has contact		
	towards the 4th toe.	•			podiatry and scheduled a facili	-	
	-Left foot				visit on 12/21/21. Any resident		
	I -	at toe was yellow and			that consents to podiatry will b	е	
	extremely thick.				offered services at that time.		
		toe was long, thick, yellow					
	and curved towards	the great toe.			3. On 11/9/21, Director of		

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Facility ID: 000478

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155494	B. W	B. WING		11/09/2021	
				CTREET	ADDRESS OF A TE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE		
					TODD DR		
WATERS	S OF SCOTTSBUR	G, THE		SCOTTSBURG, IN 47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	The nail on the 3rd,	4th, and 5th toes were			Nursing and Executive Director	r	
	observed to be long	and extended beyond the top			reviewed the procedure for		
	of the toes.	•			"Specialists visits" including		
					podiatry services and revised	the	
	The physician's ord	er, dated 1/22/19, indicated			process to include monthly		
	the resident may be	seen by the podiatrist.			reporting by Social Services to)	
	-				the Executive Director regarding	ng	
	The clinical record	indicated the resident was			routine podiatry visits.	-	
	last seen by the pod	liatrist on 10/16/2019.					
					On 11/27/21, the Executive		
	During an interview	on 11/5/21 at 2:45 p.m.,			Director-initiated education wit	:h	
	QMA 14 indicated	the podiatrist had not been in			social service staff regarding t	he	
	since COVID started.				revised process for reporting		
					podiatry services/schedules. T	he	
	During an interview	on 11/5/21 at 3:03 p.m., the			Director of Social Services is		
	Social Services Dir	ector indicated podiatrist had			responsible for monitoring		
	been coming in, but	once COVID-19 came, they			podiatry needs, obtaining		
	stopped coming in.	They signed on a new			consents and implementing th	е	
	podiatry company of	on May 1, 2021, however,			schedule for routine services f	rom	
	they had not been in	n yet. She did not have any			podiatry.		
	consents as the new	company took care of the					
	consents and treatm	ent care.			<i>4.</i> On 11/26/21, a Foot		
					Care/Podiatry Review Audit v	was	
	2. The clinical reco	rd for Resident H was			reviewed and accepted by the		
	reviewed on 11/8/2	1 at 9:37 a.m. Diagnosis			Quality Assurance Performand	ce	
	included, but was n	ot limited to, diabetes. The			Improvement Committee. The		
	resident was admitt	ed on 10/16/20.			Director of Nursing /Designate	:d	
					Administrative Nursing Staff w	ill	
	On 11/5/21 at 3:36				complete random Foot Care		
		dent H's toenails were made			reviews using the Foot		
	·	ssistant Director of Nursing):			Care/Podiatry Quality Review		
	-Right foot				Tool, to validate that residents		
	_	at toe was extremely long,			receiving appropriate foot care	,	
	yellow, and thick.				and podiatry services.		
		toe was thick and yellow.					
	The nail on the 4th				The Foot Care/Podiatry Qualit	-	
		toe was long and thick.			Review will be completed on fi		
	-Left foot				residents a week for twelve we		
	_	at toe was yellow, thick, and	1		to ensure appropriate foot care	e	
	the nail bed was ob	the nail bed was observed to be jagged.			and referrals. Any concerns		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		155494	B. WING		11/09/2021	
		100101			11/00/2021	
NAME OF P	ROVIDER OR SUPPLIEF	3	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDEN ON SOLVEIE	•	135	0 N TODD DR		
WATERS	OF SCOTTSBUR	G, THE	sco	OTTSBURG, IN 47170		
are m	arn a contra					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	The nail on the 2nd	toe was extremely thick and		identified during the reviews w	/ill	
	yellow.	·		be addressed at the time of th		
		toe was long, sharp, and		review and additional education		
	curved over the top	of the toe.		will be completed at that time.		
				Following the initial twelve-we	ek	
		er, dated 6/30/21, indicated		audit, the Foot Care/Podiatry		
	the resident could b	e seen by the podiatrist.		Quality Review Audit will be		
				completed on ten residents a		
	The clinical record	lacked documentation of any		month for four months. The re	sults	
	podiatry visits.	•		of these audits will be submitte		
	r			the Quality Assurance		
	On 11/0/21 at 11:29	8 a.m., the Executive Director		Performance Improvement		
	•	copy of the document titled		Committee monthly. The QAP	1	
	"Physician/Physicia			Committee will determine if		
	Practitioner/Clinica	ll Nurse Specialist Visits" and		additional education or		
	undated. It included	l, but was not limited to,		competencies are required, ba	ased	
	"PurposeTo ensur	re that all residents receive the		on the compliance reported from	om	
	care and services th	at meet their medicalneeds.		the Quality Reviews. Audits w	ill	
		esidents are seen regularly"		continue monthly until 100%		
	10 0115 0110 0110 0111 11	estacine are seen regularly		compliance has been determine	ned	
	This Federal tag rel	atas to Complaint		by the QAPI committee.	led	
	_	ates to Complaint		by the QAPI committee.		
	IN00365903					
	3.1-47(a)(7)			_		
				Date of Completion- 12/2/202	1	
				·		
F 9999						
1 3333						
DI 1 00						
Bldg. 00						
		8 Infection control program	F 9999	1. 1. On 11/10/21 th	12/02/2021	
	Authority: IC 16-28	3-1-7		Executive Director submitted	3	
	Affected: IC 16-28-5-1			report to the Red Cap system		
	Sec. 18. (b) The fac	cility must establish an		showing positive results for sta	aff	
		ogram under which it does		members 5,6,7,8,and 9.		
	the following:					
	_	nicable disease to public		2. 2. No other reports		
	health authorities.	incapic disease to public		· ·		
	neatin authorities.			were identified as missing in F		
				Cap during the survey review.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155494	B. W	B. WING		11/09/2021	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			TODD DR		
WATER	S OF SCOTTSBUR	C THE			SBURG, IN 47170		
		G, 111L		30011	3B0NG, IN 47 170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and record review, the					
	-	sure COVID-19 positive staff			3. On 11/9/21 the Executiv		
	_	e appropriate agency for 5 of			Director and Director of Nursi	ng	
		eviewed for facility reporting.			reviewed the process for		
	(Staff Members 5,	6, 7, 8, and 9)			reporting data in the Red Cap)	
	E' 1' ' 1 1				system.		
	Findings include:						
	Daviery of the line	list for Contambor 2021 and			On 11/10/21, the Executive		
		list for September 2021 and			Director-initiated a tracking		
	October 2021 indicated the following positive staff members:				system for Red Cap reporting		
	start members:				requires all positive reports to		
	On 00/11/21 Staff Mambar 5 tosted positive				printed prior to submitting the		
	- On 09/11/21, Staff Member 5 tested positive for COVID-19.				positive results in the Red Ca	-	
	- On 09/12/21, Staff Member 6 tested positive				system. Printing the report pri		
	for COVID-19.	1 Wellber o tested positive			submission will allow the facil	-	
		f Member 7 tested positive			maintain proof of the report be	-	
	for COVID-19.	i wemser / tested positive			made in the Red Cap system.	•	
		f Member 8 tested positive			4 On 11/00/01 a Pad Car		
	for COVID-19.	rinemoti e testes pestave			4. On 11/26/21, a Red Cap Review Audit was reviewed a		
	- On 10/18/21, Staf	f Member 9 tested positive			accepted by the Quality	ariu	
	for COVID-19.	1			Assurance Performance		
					Improvement Committee. The	_	
	Review of the RED	Cap system lacked			Director of Nursing /Designate		
	documentation that	Staff Member 5, 6, 7, 8, and			Infection Control preventionis		
	9 had been reported	1.			complete random Red Cap	C WIII	
					reviews using the Red Cap Q	ualitv	
	During an interview	v on 11/8/21 at 2:22 p.m., the			Review Tool, to validate that	<i>,</i>	
	Administrator indic	cated all of the positive staff			positive Covid tests are repor	ted	
	had been reported,	however, she did not have any			in the Red Cap reporting syst		
	confirmation.				within 24 hours of positive res		
		8 a.m., the Executive Director			The Red Cap Quality Review	will	
	_	copy of the document titled			be completed five times a we		
		Reporting Summary" dated			for twelve weeks to ensure		
		ed, but was not limited to,			documentation is maintained	to	
		OVID-19 Point-of-Care			support Red Cap notifications	Any	
	(POC) test - staff				concerns identified during the	-	
	_	rm Care COVID-19 Reporting			reviews will be addressed at t		
	form (REDCap)/Within 24 hours of result"				time of the review and additio	nal	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155494		A. BUILDING 00 B. WING		COMPLETED 11/09/2021			
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				education will be completed at time. Following the initial twelve-week audit, the Red Ca Quality Review Audit will be completed on ten times a mon for four months. The results of these audits will be submitted the Quality Assurance Performance Improvement Committee monthly. The QAP Committee will determine if additional education or competencies are required, be on the compliance reported from the Quality Reviews. Audits with continue monthly until 100% compliance has been determine by the QAPI committee.	ap th to I ased om		

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